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INEQUALITIES AT WORK:
HEALTH CARE WORKERS AND CLIENTS IN A COMMUNITY CLINIC

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A dissertation submitted to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Department of Sociology

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ABSTRACT

NATALIA DEEB-SOSSA: Inequalities at Work: Health Care Workers and Clients in a Community Clinic
(Under the direction of Sherryl Kleinman)

My dissertation is a study of health care workers and clients in a private, not-for-profit health care center. Through participant observation and in-depth interviews I analyze how workers at a community clinic reproduce or respond to inequalities of race, class, and gender in their interactions with each other and in their daily work with poor clients, especially Latinas/os.

As a symbolic interactionist and feminist ethnographer, I studied how health care providers came to act as they did as well as the consequences of their behavior for their clients, other staff, and themselves. I identify how inequality was reproduced, including the interactions, roles, identities, meanings, and emotions that were central to the people at the clinic.

In Chapter 1, I explore how the Black female staff draw on racialized and gendered rhetorics to criticize and claim status over Latinas. These rhetorics followed from the discourses constructed and used by white elites to reinforce racism and sexism. Black women used these rhetorics as a way to respond to the changes in the racial make-up of clients and the accompanying hiring of bilingual staff, mostly Latinas. Similarly, Latinas used images of pushy, bossy, and "uppity Black women" against the Black staff. I argue that these strategies

divided low-status workers. In Chapter 2, I examine how the Maternity Care Coordinators (MCCs) maintained a moral identity as good health care providers. The MCCs defined Latinas as the "neediest of the needy" and "Americans" as the privileged clients. They thought differently about the Latina, Black, and white women they served. In Chapter 3, I explore how the white high-status staff's solidarity-talk kept them from seeing the significance of race in interactions among staff members. The rhetoric used largely by the white high-status staff protected them from having to "see" their own race and did not help Latina and Black staff develop solidarity. Finally, in the conclusion I highlight how the staff might have come to recognize racism, sexism, and class inequality if organizational arrangements had been different.

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INTRODUCTION

> Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly.
>
> Martin Luther King Jr.
> Letter from Birmingham Jail
> April 16, 1963

In 1998 I was the first Latina to enter the graduate program in the Department of Sociology at UNC-Chapel Hill. I felt "different" among the mostly white students and faculty. A brown skinned Latina, born and raised in Bogotá, Colombia, I found myself in a milieu in which no one looked like me, no one spoke Spanish, and I was often asked to represent "the Hispanic community," saying what Hispanics thought about an issue or event. As a result, I went outside the university to find a Latina/o community with which to interact. I found that I was both similar to and different from the Latinas/os living in North Carolina.

I soon learned that most of Latinas/os in North Carolina (65%) are from Mexico, young, and have little education. They escaped poverty and violence in their home countries and came to "el Norte" in pursuit of the "American dream." I became a Spanish-English translator for the Latinas/os I met. I had better skills to negotiate with schools, social services, the police, and other service organizations, so I became a resource for Latinas/os. I helped them register their children for Medicaid or NC Health Choice and I accompanied Latinas to denounce their rapists to the police. After witnessing the lack of Spanish-speaking mental health care providers, I helped establish the first support group in the area for Latinas

experiencing post-partum depression and have been a resource for that group over the last five years. Since 2002, I have volunteered as a Spanish language translator for Latina clients at local clinics and hospitals.

These experiences allowed me to see the daily struggles of Latinas and Latinos. When it was time to choose a dissertation topic, I knew I wanted to give voice and legitimacy to the problems Latinas and Latinos encounter while trying to access health care services. As a volunteer in the Latina/o community, I had observed the barriers Latinas/os faced in accessing services, including lack of money, lack of information about the U.S. health care system, who to talk to, and where to go. Spanish-speaking health care providers and translators, as well as information about alternative sources of funds or payment plans, are sorely lacking. As a Latinafrom a mostly middle-class background who held advanced degrees, I recognized my educational and class privileges. I hoped those privileges (i.e., speaking English and Spanish, having an M.A.) would help me gain entrance into a health care setting.

I decided to study "Care Inc." [1] a private, not for profit community clinic that provides comprehensive care and education to racially and ethnically diverse clients, mostly Latinas/os. Using fieldnotes from participant observation and transcripts of in-depth interviews, I analyze how health care workers reproduced or responded to inequalities of race, class, and gender in their interactions with each other and in their daily work with clients. I examine these inequalities in a setting in which health care providers faced an overload of clients and were understaffed.

[1] All names of places and people are pseudonyms.

This study is grounded in the symbolic interactionist (or interpretative) perspective in sociology (Mead 1934; Blumer, 1969), especially as it applies to the reproduction of inequality (Schwalbe et al., 2000), I focus on how health care providers came to act as they did as well as the consequences of their behaviors for their clients, other staff members, and themselves. I also approach this study from a feminist (Frye 1983; Bartky 1990) perspective and use the methodological approach of grounded theory (Charmaz 2000). Grounded theory is an inductive and deductive process where bytheory emerge s from data and is then tested (grounded) against "the real world" (Charmaz 2000: 513-4).

Mead's (1934) pragmatism provides the basis for symbolic interactionism. For Mead, membership in a group gives rise to a set of shared meanings. The different positions and roles individuals hold in a group create differences in people's meanings and behaviors. Mead also contends that culture and social arrangements guide people's behavior rather than rigidly determine it. People can, through individual or joint action, create new meanings, behaviors, and organizational arrangements. Blumer (1969) extended Mead's ideas and spelled out three core premises of symbolic interactionism:

> …human beings act toward things on the basis of the meaning of such things…meanings [are] social products…creations that are formed in and through the defining activities of people as they interact…[A]nd…the use of meanings by a person in his [or her] action involves an interpretative process (2-5).

Some interactionists focus on how people's joint actions create and sustain interactional patterns of equality or inequality. Schwalbe et al.'s (2000) "sensitizing theory of generic processes in the reproduction of inequality" guides my study by alerting me to the ways in which inequalities are reproduced.

Even before the first day of fieldwork (as aresearcher and volunteer), I was eager to explore how white U.S. health care providers, especially those facing difficult working conditions at community clinics, responded to Spanish-speaking immigrants. Did the health care providers share the fear and resentment of some North Carolinians about the influx of Latinas/os? (see Hyde and Leiter, 2000; Hemming et al. 2001). How did decreases in health care services for immigrants (which put more pressure on those that exist) and increases in anti-immigrant attitudes by North Carolinians shape health workers' conceptions of Latinas/os?

During the year and a half of fieldwork I felt at home at the clinic in many ways. I was surrounded mostly by Latina and Latino clients who came for medical care. I felt comfortable with the familiar smells, hearty voices and laughs, colorful clothes, and children running around the clinic. Our commonalities—and my relative privilege—made it easy to feel sympathetic to their plights as poor immigrants. The Latina/o clients were mostly undocumented and spoke little English. Like them, I felt stigmatized by being a brown-skinned Latina in the U.S.

I also hit it off well with the Latina staff. We often shared our difficulties understanding Southerners, especially when they spoke fast and used slang terms. We also felt inadequate because of our accents. Latina staff and I recalled memories of our youth, especially holidays and the banquets served by our grandmothers and mothers. And we shared a concern for the plight of poor Latina/o clients.

It was much more difficult for me to interact with the Black and white (female) staff at the clinic[2]. Because they worked at a community clinic that served mostly Latinas/os, I

[2] Of the forty employees, 13 were white, 14 were Black, and 12 were Latinas.

expected them to serve as allies to Latinas/os. But, given the history of racism in the U.S., I thought I might find some discrimination on the part of white staff toward Latinas/os (staff and clients), and between white staff and Black staff and white staff and Black clients. That was not what I found.

I observed hostility between the Black staff and Latina/o staff, between Black staff and Latina/o clients, and occasionally Latina staff and Black clients. I thought Blacks and Latina/os would have solidarity, given their shared racial/ethnic and class interests. Initially, I could not understand why the Black staff were so rude to Latina/o clients. Why didn't they want to help those who needed them ? Why didn't the Black staff take out their frustration on the privileged white staff? Early in my fieldwork, I typed furiously in my notes about how Black staff were "just, so bad." For example, when I worked alongside the Black receptionist at the clinic, she would hang up the phone and forward a call from a Spanish speaker to me, saying: "Some people call so much, they drive you crazy." She also complained constantly about the noises made by the children in the clinic's waiting room. More specifically, she would complain about the Latina/o children, saying things like, "Don't they know this is not a playground? They are driving me crazy!" Once she remarked to me about three Latino five year-olds, "Don't they go to school? You just see them so often that you start to wonder what they do all day."

It was also common for the receptionist and the triage nurse (both Black women) to comment on the Latinas' parenting skills (Latinos, the men, were not judged for their parenting abilities): "I've got to fuss all day at these kids. They have no home training…. Jesus!" On another occasion one of them said: "Where are these kids' mothers? We would never let our children behave like this." The "we," it seemed, were Black women.

When I translated Spanish for the Black lead nurse, she often asked me why “your people” would do things that were “just not right.” She made it clear that she, and by implication other Blacks, would act differently (i.e., learning English and not bringing children to the clinic).

I knew that Latinas/os experienced racism, a system that grants or denies access to social, economic and political power based on race. “Blacks, like whites, are racist,” I usually shouted as I typed my fieldnotes. “Both groups, in addition, have U.S. privilege,” I added. I noted that Black staff had commented that “it is so much better here in the U.S.” compared to “those poor messed up third world countries.” Their comments painted Latin America as the 'other', a backward area of the world.

As a Latina focused on helping poor Latinas/os, I had thought lessabout white racism against Blacks in the U.S. As an immigrant with a student visa, I, like the Latina staff, emphasized the privileges Black staff and clients had when compared to Latinas/os. Didn’t Blacks share the privileges accorded to all U.S. citizens? Like the Latina staff (see Chapters 1 and 2), especially the Maternity Care Coordinators (MCCs), I saw Latinas/os clients as the "neediest of the needy" and expected all the workers to share this view. If not, why work at the clinic?

Only after being in the field for a while did I learn that the clinic was located in a mostly African-American neighborhood and thatwhen it opened in the early 1970s, most of the staff and clients were also African-American. Only after many months of fieldwork did I come to understand how racism and class inequalities shaped Black workers’ responses to the increasing demands for health services by Latinas/os moving into the state. I also came to understand why Black workers resisted the efforts of the white clinic’s administrators and

white doctors to accommodate Spanish-speaking immigrants. Over time, I developed empathy for the Black staff and the challenges they faced in trying to make sense of the decreased availability to African-Americans of social services, educational resources, and jobs.

In the context of the continuing influx of Latinas/os to North Carolina, it is important to assess how Latina/o immigration is influencing how work is done at community clinics, including its consequences for Black staff and clients. My study may well have implications for other community agencies and organizations stratified by race/ethnicity.

<u>The Community Health Center Program and Care Inc.</u>

The neighborhood health centers, also known as community health centers, were a result of President Johnson's "War on Poverty." In the early 1960s, the U.S. federal government took on the responsibility of providing health care services and increasing access to health care for the elderly and the poor. Both Medicare and Medicaid were enacted into law in 1964. These two programs were designed to increase access to health care for the elderly and the poor by having the government pay providers and hospitals for medical services.

In 1965 the U.S. Office of Economic Opportunity (OEO) gave grants to community groups—health departments, community organizations, hospitals and medical schools—to set up and administer health centers in poor neighborhoods. The idea was that these health centers would "provide high-quality health care to low-income populations lacking access to such care and, at the same time, serve as a model for the reorganization of health care services for the entire U.S. population" (Sardell 1988:4). This radical health services innovation was a response to the "discovery of poverty…a fear of urban unrest…and a

broader concern for the needs of the urban poor, primarily minorities" (Sardell 1988:6). The survival of the health center program was in question when President Nixon and President Ford, both Republicans, took office. Nixon, for example, planned on reducing Johnson's social programs and placing health initiatives in the private sector.

The health center program survived and was later expanded by President Carter. By 1980 approximately 880 community centers existed and were providing medical health services to approximately six million people (President's Commission, vol. 1 1983:131). In 1995, the National Association of Community Health Centers reported that 822 health centers operated in the U.S. and served almost nine million patients (NACHC 1996). In 2001, 845 health centers operated in the U.S., serving almost 12 million clients (Rosenbaum and Shin 2003:3). Slightly over half of them (51 percent) operated in rural communities (Rosenbaum and Shin 2003:2).

In the U.S., the poor and elderly are disproportionately female and the poor are also disproportionally people of color. This is reflected in the statistics on who uses community health centers like Care, Inc. In 2001, 59 percent of all health center patients were female and 64 percent were members of racial or ethnic minority groups. Thirty-five percent were Hispanic and 25 percent were African American (Rosenbaum and Shin 2003:6).

Some community health centers emerged from working class and anti-racist social movements. Common goals forged close ties between members of the civil rights movement and members of the community health center movement. The health needs of Black communities, particularly in the South, often led the Black community and people involved in the civil rights movement to establish health centers (Couto 1991, Keifer 2000). The

community clinic I studied was established by prominent members of the Black community in North Carolina to help meet the health care needs of Black people.

Today, people of color, immigrants, the elderly, and the poor still have difficulty accessing quality health care. As Bayne-Smith et al. (2005:25) explain:

> Historically, race in the United States has served as the basis for denial of social justice and access to resources and critical services. However, it is now of serious concern that in the opening decade of the twenty-first century, the burden of health disparities in the nation continues to fall primarily on the poor, a disproportionate number of whom are members of racial and ethnic populations.

According to recent estimates there are more than 10 million undocumented immigrants currently living in the U.S. (Passel 2005). Because immigrants are more likely to lack private insurance and have the lowest rates of public insurance, they are more likely than citizens to rely on community clinics for health services (Staiti et al. 2006:1). The demand on community health centers by immigrants (undocumented or not) varies by state (and city). The states of California and New Jersey and the cities of Miami and Phoenix have had to respond to immigrants' demands for health services for many years. Other states have few year-round immigrant residents. States such as North Carolina and Arkansas are only recently confronting a large influx of immigrants from Latin America; they are coping with new, sudden, and urgent problems (Staiti et al. 2006: 2):

> …undocumented immigrants can typically access primary care through safety net providers, but providers report more difficulty referring undocumented immigrants for specialty care. In several communities, waiting times to see specialists in safety net hospitals have reportedly increased, with waiting times the longest for the uninsured. Other problem areas mentioned include the provision of chronic care treatment, mental health care and obtaining affordable prescription drugs, because program rules often impede services for undocumented patients (Staiti et al. 2006: 2).

The same study reported that immigrants trying to access health care face language and cultural barriers and well as political backlash and anti-immigrant initiatives attempting to limit social service (Staiti et al. 2006:3).

Community health centers have become a major source of health care for the poor (Kiefer 2000). According to a report by The Commonwealth Fund (Collins et al. 2002), 20% of Latinas/os in the U.S. regularly go to a community health center for medical care. Community health clinics are also a significant source of health care to the non-Hispanic poor: 10% of American Americans, 8% of Asian American and 7% of Non-Hispanic whites use health centers as their usual source of care in the U.S. (Collins et al. 2002). This same survey found that 28% of Latinas/os, 24% of Asian Americans, 22% of African Americans, and 15% of Non-Hispanic whites feel they have "very little choice," or "no choice" in where they obtain health care, and rely either on area community health centers or hospital emergency rooms. About 14% of Latinas/os fall back on emergency rooms —or have no source of care—compared to 6% of non-Hispanic whites, 8% of Asian Americans, and 13% of African Americans.

The lack of affordable health insurance and the rising costs of health care are two of the factors accounting for the sub-optimal quality of and limited access to medical care for the poor. According to the U.S. Census Bureau Poverty Report (March 2002), 22.7% of African Americans, 21.4% of Latinas/os, 10.2% of Asian and Pacific Islanders, and 7.8% of non-Hispanic whites live below the poverty level (Census Bureau, March 2002). Latina/o adults have the highest uninsured rates of any racial and ethnic group in the United States. According to findings from The Commonwealth Fund's 2001 health care quality survey, 46% of Latina/o adults did not have health insurance for all or part of 2001. The uninsured

rates for non-Hispanic white, Asian American, and African American adults, while lower, are nonetheless high: 20%, 21%, and 30%, respectively.

For most community clinics, public funding is vital. Community health centers receive funding from Medicaid, Medicare, state and local funds for indigent care, and from Public Service Act Grants for health centers, migrant workers, and the homeless. The health centers also depend on payments from health insurance companies and direct payment from patients (Keifer 2000: 147).

Community health centers vary by mission, size, and budget, but most of them are non-profit organizations whose board of directors have financial and policy oversight (see Figure 1; Bayne-Smith et al. 2005: 41). The day-to-day operation of the organization falls to the executive director. The executive director reports to the board of directors and trustees. The executive director is counseled on how to run the health center by its managerial staff, which might include the center manager, the fiscal manager, the director of personnel, the different unit directors, and accountants. Direct services to clients are provided by the clerical support staff—receptionists, patient care coordinators—and the health care providers that include doctors, nurses, and medical assistants (Bayne-Smith et al. 2005: 43).

The layout of each community clinic varies depending on the building, size and the services provided. However, the layout of Care Inc., the community clinic I studied, was similar to that of other community clinics I have visited in North Carolina (see Figure 2). It was a one story building in a predominantly black neighborhood. Just inside the clinic doors, several rooms surround a waiting room. To the left clients find the dental unit and the pharmacy. To the right are the registration office, now separated from the waiting room by a glass window, and the reception area. Behind the reception area are small rooms where the

patient care coordinator, the billing unit and the medical records unit are located. At the end of the hall to the right, there is another waiting area. Here clients wait to see the triage nurse or the doctors. Large glass windows separate the clinic unit from the waiting clients, allowing the latter to see the medical assistants, nurses and clinicians at work. A hall on the left leads clients past the pharmacy to the Women Infant and Children program (WIC) and Maternity Care Coordination "units," as clinic staff called them. Clients of these units wait in another small waiting area with a glass window. Given the set-up of the clinic, the low-status staff members—Black and Latinas—were in direct contact with the clients, while the white high-status staff had more shelter from clients.

Care Inc. provides health services to low income people who receive inadequate health care and whose access to health services is restricted especially by their lack of health insurance. As a community clinic, Care Inc. provides health services to people in need who reside in the town and surrounding areas. The demand for health services at this clinic exceeds the center's capacity. Many new clients wait three to six months for an appointment. This is not surprising since 16.5 percent of the 1.3 million residents of North Carolina lack health insurance (U.S. Census Bureau, 2004 Current Population Survey).

Care, Inc. is a partially federally funded not-for-profit clinic open to the public Monday through Friday. This clinic provides health care services and education to more than 5,500 clients a year. Sixty-six percent of Care, Inc.'s clients are female. Fifty-seven percent are Latinas/os, 17 percent are white, 16 percent are Black, one percent are American Indian, and one percent are Asian.

The clinic offers "comprehensive" services. These include primary and preventive care for children, teens, adults, and older people; physical exams; and laboratory and flu shots.

The clinic also provides reproductive health services: family planning, free pregnancy testing and counseling, child birth classes, maternity care coordinators, maternal outreach, certification for the Baby Love Program for Prenatal Care,[3] and gynecology services (including pap smears). In addition, the clinic offers nutritional services: Women, Infant, and Child Nutrition Program or WIC, and Nutritional and Dietary counseling. Clients also have access to a pharmacy and to dental services[4].

Care Inc. is one of seven clinics run by a corporation I call “Health Services Cooperative” or HSC. When I started my research, this private not-for-profit corporation had been in operation for some thirty years. As a community health provider HSC receives some funds from the Department of Health and Human Services. According to the Training Manual, HSC aims to

> assur[e] the availability of affordable primary care services to special populations in the greatest need. Special emphasis is placed on maternity and infant care through a comprehensive perinatal care program… [and in] providing high quality of care to all of [their] clients and improving the overall health of [their] communities.

Care, Inc. provides primary care services to over 75,000 clients in six counties. A major emphasis of Care, Inc. and five of its sister clinics is “health promotion and disease prevention as well as acute and chronic primary care treatment for families and individuals”

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[3] The goal of the Baby Love Program, which began in 1987, is to reduce NC's high infant mortality rate by improving access to healthcare for low-income pregnant women and children. Through the program women receive care from the beginning of pregnancy through the postpartum period. Nurses and Maternity Care Coordinators (MCCs) help women obtain medical care and social services (i.e. transportation, housing, job training and day care). In addition Maternal Outreach Workers – specially trained home visitors—work with at-risk families to encourage healthy behaviors, and ensure that they are linked with community resources. Other services include childbirth and parenting classes, in-home skilled nursing care for high-risk pregnancies, nutrition and psychosocial counseling and postpartum/newborn home visits. (See: http://www.dhhs.state.nc.us/dma/babylove.html)

[4] Dental services were terminated in October of 2002 but re-opened in 2003.

(HSC flyer). One of HSC's centers also offers obstetrical services. ("Brief History of HSC," Training Manual).

From its inception in the early 1970s, Care Inc. has mainly served the poor. In the mid-1970s, Care Inc.'s clientele was predominantly African American. Today its users are primarily Latinas/os. The changing demographics at the clinic reflect the fact that North Carolina has one of the country's highest rates of Latina/o immigration in the United States. Since 1990 some southern states, including North Carolina, have become common destinations for Latina/o immigrants. According to the U.S. Census Bureau, North Carolina's Latina/o population grew 394 percent from 1990 to 2000 and now accounts for 4.7 percent of the state's population. For the U.S. as a whole the growth in the Latina/o population during this same decade was only 60 percent. The changing demographics of NC and their effect on the staff and client base of Care, Inc are at the core of my story about racial conflict among the staff.

There are approximately 40 employees at Care Inc. During my fieldwork, some workers moved to other clinics. Staff members from other HSC clinics also came to work at Care Inc. Others quit or were put on notice by the center manager. Some new staff members were hired.

Of the 40 employees, 13 were white, 14 were Black, and 12 were Latinas. Most employees were between 30 and 50 years old. Ninety-five percent of the employees were women; only three men worked at the clinic during my fieldwork: a white doctor, a Black WIC administrator, and – for just one month – a Black receptionist. No Latino men worked at the clinic.

The overwhelming presence of female staff at this community clinic is explained, in part, by gender segregation in the health labor force (Butter et al. 1985). Female physicians tend to specialize in public health, pediatrics, and psychiatry, while male physicians tend to specialize in fields such as surgery and pathology. As Butter et al. (1985: 25) explain, "Historically women physicians have had a propensity to cluster in salaried employment and in bureaucratic work settings in contrast to the highly autonomous, self-employed practice mode of their male peers." Community clinics like Care Inc., then are often staffed largely by women and, since there are usually more low-status jobs than there are high-status jobs in such clinics, the majority of staff members are likely to be women of color.

The health field is also racially segregated. People of color make up the majority of low-status health care providers and the more prestigious and better-paying sector is dominated by whites. The intersection of racial and gender segregation results in a staff profile like that of Care Inc. and of most community clinics. Nurses, social workers, health educators, and medical assistants are predominantly women; white women hold the higher-paying of these jobs and women of color fill the positions at the lower-paying level.

The historical and persistent links among social justice movements, government anti-poverty programs, and community clinics also attract workers who see themselves as promoters of equality and empowerment. At Care Inc., female staff, particularly those in high-status positions, saw their work as helping and empowering those who needed them the most. For example, all Maternal Care Coordinators, both white and Latina, asserted that Latina clients were especially "needy" and deserving of special protection.

At Care Inc., the racial composition of the staff seemed relatively balanced on the surface. Most of the powerful and prestigious positions were held by whites, however; they

were the clinicians, the directors of all the units, and the center manager. The Maternity Care Coordinators (MCCs)—two Latinas and two whites —occupied a mid-level status. Most of the Black staff worked in low-status positions such as receptionist, medical assistant, laboratory technician, WIC/Nutrition Department coordinator, and nutritionist. Most of the Latinas also held low-status positions, working as receptionist, client care coordinator, medical assistant, laboratory technician, WIC administrative assistant, and pharmacy assistant. There were exceptions at the top. The executive director, whose office was not on site, is a Black man. A Black female clinician initially worked at Care Inc. two days a week, but soon quit to go into private practice. A Black woman held the position of lead nurse.

Although their jobs were low-status, several of the Black women held positions that gave them some "gatekeeping" power over clients. For example, the Black triage nurse and the Black receptionist had the power to decide who could see a provider. The triage nurse saw all patients who came to Care Inc. without an appointment. She decided who would be seen that day and who would have to come back or give up. During my time at Care Inc., she often used this power selectively against Latina/o clients. She told me that the Latinas/os "work the system" and at times sought unnecessary medical care for their children, by lying or getting their children to lie.

The receptionists were also "gatekeepers;" clients were forced to talk to them in order to get an appointment with a doctor. I observed many times when the Black receptionist told a Latina/o patient to call later because she did not speak Spanish. If Latina/o clients waited to call back, when they called again they were told that there were no more appointments available for that month. This receptionist also often put the Latinas/os who were new to the clinic on a three or four month waiting list to see a doctor.

Konrad et al. (1998) found that in private practices, staff often blocked particular patients' access to doctors. In their study, actors who played mothers who had insurance, mothers who were uninsured, or mothers on Medicaid were treated quite differently. Medicaid and uninsured patients had the most difficulty getting help for their babies. Staff members' negative attitudes toward these patients amplified and reinforced the financial and non-financial barriers to health care already faced by uninsured and Medicaid patients. This study suggests that receptionists' views about a stigmatized or oppressed group can determine whether members of that group get care or not. This power without status or pay is in many ways a limited power; it is hard to see how Black people actually benefit from denying Latinas/os health care. But in a context of limited and shrinking resources, particularly for one's own oppressed racial group (here Blacks), this can seem like real power with real if only immediate and short term effects.

Care Inc. was a very busy and under-resourced place. The 40 employees worked in one of six different "units," but some of the staff frequently had to work in several different areas because of patient demand. I observed staff from the reception area doing registration, billing, client care coordination, and medical records in one workday. This muti-tasking was expected; and the Training Manual describes this as the "team philosophy." It may be "teamwork" but it is also stressful and can interrupt or abbreviate the training of a worker in her specialty.

Care Inc. charged clients for services based on their ability to pay[5] because, as is asserted on the HSC's website:

[5] For a client to be considered for a low fee, as determined by federal guidelines, the client had to provide the clinic with: (1) proof of address, (2) proof of household income, and (3) an insurance card, if s/he had it. Proof of address could be either an envelope or a copy of a bill

> many people in the areas our clinics serve are in “underserved areas,” meaning there is not easy accessibility to medical care, or there may not be accessibility to affordable medical care. Our goal, our mission, is to provide quality medical care for all people.

This system increases accessibility (and therefore demand) and reduces the resources available to the clinic to meet that demand.

Scarcity in the clinic is situated in a larger context of changing demographics and the perception, at least particularly among African Americans in the state, that immigrants are taking away “their” (very limited) services. The unprecedented Latina/o immigration to North Carolina has been accompanied by racial tensions. When North Carolinians — Black and white— were asked in 1996 about the increase of the Latina/o population in North Carolina (from 1.2 percent in 1990 to almost three percent in 2000), 40 percent of respondents said they were unhappy about it and that growth was a problem. When asked if they would like it if Hispanics moved into their neighborhoods, two thirds said they would not, and more than 90 percent said they would dislike having Hispanics as neighbors (Hyde and Leiter, 2000).

A major oral history initiative launched by the Southern Oral History Program at the University of North Carolina-Chapel Hill has documented these racial tensions and struggles among “old-timers” and their “new” neighbors in various communities in North Carolina. One project (“New Immigrants”) focused on the impact of Latina/o immigration in Durham.

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from the telephone company, electric company, or a copy of a lease, rental agreement, etc. To provide proof of household income, all members of a household had to supply proof of income. A wife had to document her income and that of her husband. People living together and sharing income, even if not related, had to supply proof of income for each individual. A client also presented all insurance cards, whether the insurance was private or public. If a client's household income was at or below the poverty line (determined by the Federal Government), s/he was charged scale fee “A”, she did not have to pay for medical care. A client whose household income level was at least twice the poverty level was charged scale fee “E”, she paid 100% of the cost of the services rendered.

Jill Hemming, Alicia J. Rouverol, and Angela Hornsby recorded “life … before the arrival of Latino newcomers, the experience of Latino immigrants, and the challenges that Blacks, Latinos, and whites have faced as they find strategies to live in shared spaces” (2001:10).

The settling of the Latina/o immigrant population in North Carolina has been unprecedented, and, for many old-time residents, inexplicable. As one Black old-timer said: “I was curious to know if there’s something that’s going on in Durham that I don’t know about that’s attracting all the Latino population” (29). The influx of Latinas/os has also been associated with danger and distrust. As another Black resident explained: “You’re talking about a whole different culture that you want me to trust myself with. No, no, no, no. That’s taking me out of my comfort zone first of all, and then you are asking me to do something I don’t understand because I don’t speak Spanish” (29-30).

Another Black “old-timer” expressed strong and negative feelings about the changes in his neighborhood due to the “newcomers”:

> Well, when I started seeing the Hispanics moving in I felt that they were invading on my turf, on my playground. It was no longer our place… [In] ‘89, that’s when I started to see that the community was changing. And along in that time too crime was building. The community that I knew and loved and grew up in and felt safe in had already changed. So with the Hispanics moving in, that didn’t help any (27-29).

Many respondents also viewed Latinas/os as criminals, and as taking advantage of welfare programs and jobs at the expense of U.S. citizens, especially African Americans. As a Black “old-timer” said:

> I’ve heard horror stories how if you want to get some cheap labor you go get a Mexican. I’m talking about contractors coming in here paying Hispanics less that what they could pay an African American because they knew that they could pay them less. Maybe because they were illegal immigrants or didn’t know any better. So in turn, it was cutting out the African American from doing the only job he could do (31).

The Latinas/os interviewed were aware of others' prejudices against them. One of the new residents said: "Here, they think poorly of us. The same thing happens even at work: they always prefer people that are from here rather than people that are not from here, like us". (34).

Although some Latinas/os complained about white racism, for many the bigger problem seemed to be conflicts with Black people. As a Latina respondent said to the researchers, "I don't like the Black people; sometimes they look at us saying: 'You are nothing.'"(34-35). At Care Inc. these economic and social struggles among whites, Blacks, and Latina/o immigrants played out.

It's Not about Bad People

The health care providers at Care Inc. had good intentions and, like all of us, were responding to historical and social circumstances. Yet their actions at times reinforced racism, sexism, and class inequalities.

Some of the staff members at Care Inc. were aware of various forms of inequality, including racism. For example, the white female staff had faced sexism as young clinicians, educators, and administrators and several had been part of the women's movement in the late 1960s. Many of them were also aware of how class inequalities and racism undermine poor whites' and Blacks' health and longevity.

Without exception, the staff felt overwhelmed by the speed-up and volume of people they served on a daily basis at the clinic. All the health care workers experienced work overload and complained to each other (and to me) about it. It was common for them to keep track of the clients seen in a day and to compare it to "their record." For example, when I

began my fieldwork, the Black triage nurse frequently gave me an update, such as: “Today I saw 88 clients. Very close to my all-time record of 98 clients.” These difficult working conditions exacerbated the racial tensions—especially between Blacks and Latinas/os—found outside the clinic.

Staff in all the units I observed performed several tasks at once, faced a constant flow of clients coming in for services, and managed to meet more expectations than they could reasonably fulfill at one place and time. As one of the two receptionists told me, “the pace is relentless.” The receptionists, for example, answered the phone—which seemed never to stop ringing—took a message or transferred a call to a staff member in one of the units of the clinic, and attended to the person in line who either had an appointment with a doctor or might need a follow-up appointment. At the same time, she worked on the computer, printed an encounter form (containing the client information used by the billing department to determine fees), made copies of the insurance cards (i.e., Medicaid, Medicare, or private insurance), looked for the medical charts of clients that came in as walk-ins, and highlighted the name of the client in the schedule as a way of checking if all the scheduled clients had shown up. The bilingual receptionist, in addition to her usual tasks, translated for the triage nurse, the person in charge of medical records, and the pharmacist, as needed. All this went on all day, five days a week. As I wrote in my fieldnoteswhen I worked as a volunteer in that job:

> I feel I am on a treadmill, and that the speed it is on is too fast for me. I have too many things to do – even at the same time!— and I never seem to finish doing something before I have something else to do or someone else to help. Only once today I had a break around 6:30 p.m., when no one was in line and the phone was not ringing. I took a deep breath. I needed to catch my breath, and this was the first time I had the time to do so. I had not even taken a bathroom break, and I had been working for more than 5 and ½ hours straight! At this time I remember thinking I had more than an hour to go, since today I

> had been scheduled to volunteer from 1 p.m. to 8 p.m. I had 1 and ½ more hours! I am hungry, tired, stressed and my head is buzzing. Am I going to make it?

If the computers were down (the computers were connected to a network and to a program where all client information was kept), or the printer did not work or was out of paper, if the photocopy machine was being used by someone else, a co-worker was sick or on vacation, children were crying or running around the clinic, or there were more clients than usual, the receptionists' daily work became even more taxing and stressful.

At a staff meeting, lower-level staff said that they were "stressed out" and that the situation "is made worse when staff is out or positions are vacant." The WIC director described in a memo sent to the administrators and unit directors (and noting that this could be shared with anyone):

> It was clear from the staff meeting that [the clinic's] staff are feeling stressed by the staff shortages (medical assistant, registrar, and pending Center Manager). Staff is working with a minimal level of staffing as it is so that when staff is out or positions are vacant, a stressful situation is made worse. This is clearly noted in the breakdown of the registration system. The center needs the support of administration to see that these positions are filled as soon as possible. In addition, the underlying causes of the high turnover of center managers at this center needs to be investigated. (Memo)

Understaffing and high turnover were not the only problems staff complained about. Several staff members, especially single mothers, often griped about their meager pay and the problems they faced making ends meet. It was not uncommon to find them glancing at their checking account balance, listing the bills they had to pay, and deciding which ones they could pay and which ones would have to wait until the next pay day. The majority of the low-status staff held two jobs. This was understandable. For example, in 2002, a recently hired Medical Assistant I was paid $17,200 a year, and a Medical Assistant II was paid $18,900. A Licensed Practical Nurse was paid little more (between $19,700 and $28,700).

Maternity Care Coordinators were paid $26,000 a year, and the Registered Nurse, $31,000. Many lower-level staff held part-time jobs at night or on weekends. They worked at local nursing homes as nurses' aides or at a local hospital as medical assistants.

Fieldworker Role

I conducted this ethnography from May 2002 to December 2003, acting as a participant observer and volunteer. In the year and a half I did fieldwork I visited the clinic three days a week for five to six hours a day. In my volunteer role I "floated" through four of the six units. I observed and worked with the staff at the front desk, the maternity care coordination program, the WIC[6] and Nutrition department, and the clinical unit. I began my fieldwork after a Center Manager for the clinic was hired. I committed to work as a volunteer under the supervision of the Center Manager, where needed, for three days a week for the duration of the study. The Center Manager and I decided I would begin my one-and-a-half years of fieldwork by observing/working in the reception area. I would then observe/work in referrals, after which I would observe/work in registration and medical records. After that, I observed/volunteered for the Maternal Care Coordinators, after which I observed/volunteered for the triage nurse and the Women Infant and Children program (WIC). Finally, I observed the nursing station, the laboratory, and the doctors.

I interviewed 21 of the 40 employees, including employees who worked at the front desk (center manager, reception, registration, client care coordination [or referrals], and billing, and medical records), clinical area (triage nurse, nursing station, laboratory, and doctors),

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[6] The Woman, Infant and Children (WIC) program provides supplemental food package –in the form of vouchers—to pregnant, post-partum (up to 6 months), and breastfeeding women (up to 1 year), and infants and children up to their fifth birthday. They must meet financial eligibility (below poverty level) and be at medical/nutritional risk.

Maternal Care Coordination program, and WIC and Nutrition Department. Most of these interviews took place outside of the clinic, either during interviewees' lunch time, after work, or on a day off. Three interviews were conducted at the clinic, in an office where no one could listen in or interrupt us. Interviews lasted from one to two hours and were transcribed in full.

I ended up interviewing a greater percentage of white-high-status staff (9 out of 13 white staff members) and Latina low-status staff (8 of 12 Latina staff members) than of Black low-status staff (5 of 14 Black staff members). These numbers are not a fair representation of the amount of time I talked to the staff members, in particular to the Black low-status staff. As I worked (volunteered/observed) alongside these staff members, I conducted many informal or mini-interviews. These conversations were extensively recorded in my fieldnotes and you will see evidence of them in the following chapters.

I also spoke with clients, in particular Latina/o clients. I had already metsome of them at local churches, meetings, and events at Latina/o organizations. A few were friends. These Latina/o clients come from a community that has been described as:

> one of the mainstays of the agricultural workforce, and they are disproportionately employed in hazardous industries, such as construction, or in low-paying jobs…Almost two-thirds of North Carolina Latinos (64.2%) are foreign-born, with almost half reporting that they do not speak English very well. Over half of the Latinos in the state are noncitizens (58.3%)…Most North Carolina Latinos are recent immigrants from Mexico (65.1%)…[There are] several health issues facing Latinos in the state, including the current health status of this population; their different healthcare expectations; language difficulties; lack of health literacy; financial barriers due to lack of health insurance; inadequate state resources to address the health, behavioral health and dental needs of the growing but largely uninsured Latino population; barriers facing the migrant population; and inadequate data to monitor the Latino population's health status and access to care and services (Silberman et al. 2003: 113-114).

I also collected documents produced or used by the health care providers, as well as flyers and brochures available to clients. These provided additional sources of data about health care work.

The activities of a volunteer were well-suited to the job of observer. I hung around without being in the way, listened to and participated in conversations with staff and clients, and watched their daily routines. Asking questions was an expected part of the volunteer role.

I came to know each staff person well. They seemed comfortable talking to me about themselves, other staff, and clients (of all races/ethnicities). I wish I could say this was because of my stellar personality, but there are good sociological reasons for this. As a graduate student I had achieved a higher class status than most of the Latinas and the Black women at the clinic. Thus, for the Black staff, I may have reinforced the idea that the majority of Latinas/os are lesser—after all, I am the exception. I "proved" to the Black staff that Latinas/os could assimilate, speak English well, etc., if they chose to. In Chapter One I show that Black women on staff described Latina staff and clients as "lazy," "bad mothers," and abusers of subsidized health care, images that single outwomen . Though these stereotypes were not of their own making, Blacks drew on them to claim status over the new threatening group: Latinas/os. As a Ph.D. student, I broke the stereotype.

The Latina staff also gave me "extra points" for not being a snob and for being a committed and hard-working volunteer, despite having achieved a higher class status than most Latinas. Similarly, the white staff frequently praised me for being a hard-worker who would never say "no" when asked to do something or help someone, and who got along with everyone.

Lessons in Sexism, Racism, and Inter-Minority Hostility

In the following chapters I examine the intersections of race, gender, and class in a community clinic. In Chapter 1, I explore how the Black female staff drew on racialized and gendered rhetorics to criticize and claim status over Latinas. The rhetorics used by these Black women followed from the discourses historically constructed and used by white elites to support and reinforce racism and sexism. Black women used these rhetorics as a way to respond to the changes in the racial make-up of the population of clients the clinic was now caring for—mostly Latinas/os—and the accompanying hiring of bilingual staff, mostly Latinas. These changes put Black women's jobs, and what modest status they had achieved, in jeopardy. Similarly, Latinas in this community clinic used images of pushy, bossy, and "uppity Black women" against the Black staff. The Latinas believed Black women were influential inside and outside the clinic; they did not recognize white racism against Black people in the U.S. Within Care Inc., the differences between staff—Black women and Latinas—became exaggerated by both groups. These strategies divided low-status workers, thus masking inequalities and keeping white privilege intact.

In Chapter 2, I examine how the Maternity Care Coordinators (MCCs) maintained a moral identity as good health care providers. Kleinman (1996:5) defines moral identity as:

> an identity that people invest with moral significance; our belief in ourselves as good people depends on whether we think our actions and reactions are consistent with that identity. By this definition, any identity that testifies to a person's good character can be a moral identity, such as mother, Christian, breadwinner, or feminist.

The MCCs used three strategies to feel good about themselves as health providers: defending clients against Black staff, categorizing clients as either "Americans" or "Latinas", and making maternal health into a feminist mission. In so doing, the MCCs defined Latinas as

the “neediest of the needy” and “Americans” as the privileged clients. They thought differently about the Latina, Black, and white women they served.

In Chapter 3, I explore how the white high-status staff’s “solidarity-talk” kept them from seeing the significance of race in interactions among staff members. The rhetoric used by the white high-status staff protected them from having to “see” their own race and did not help Latina and Black staff “get along.” The white high-status staff were successful at fashioning the role of health care worker into a moral identity (a basis for feeling like a good person), but the Black and Latina lower-level staff could not sustain this construction for themselves. Understandable tensions (and at times conflict) between Latina and Black staff members stood in the way.

In the conclusion I will highlight how the staff might have come to recognize racism, sexism, and class inequality if organizational arrangements had been different.

Figure 1:

Organizational Structure

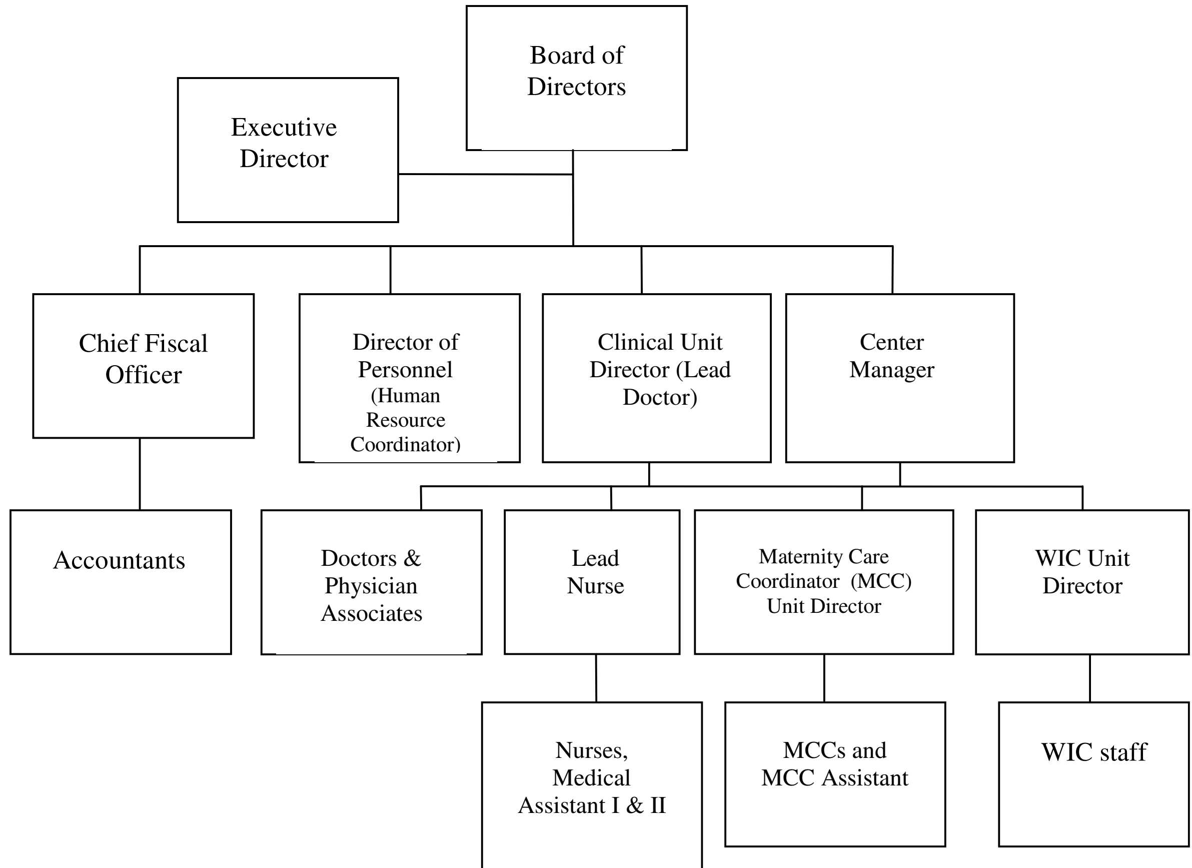
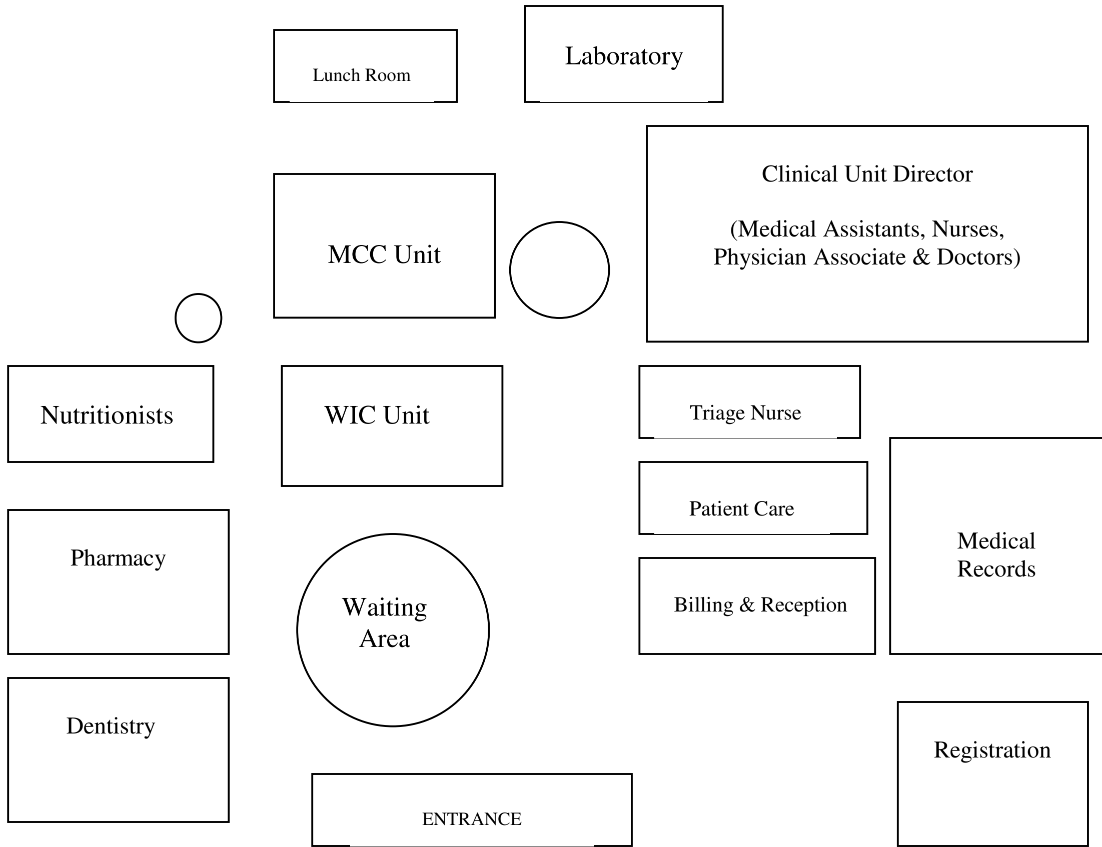


Figure 2:

Layout



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CHAPTER 1

WHERE DO WE STAND?: CONFLICTS BETWEEN BLACKS AND LATINAS IN A COMMUNITY CLINIC

Prevailing cultural rhetorics identify undocumented immigrants as primarily to blame for the poverty and job disclocation found in Black communities (Hutchinson 2006b). These rhetorics contend that employers pay undocumented Latinas/os less than the minimum wage, thus displacing Blacks from industries they once relied on (e.g., domestic labor, day labor, etc.).

The movement of Latinas/os moving into formerly Black neighborhoods, and the emergence of Hispanic-owned businesses in Black neighborhoods are causing tension between these two communities as they compete for limited resources. One point of contention is that Latinas/os are exploiting social services originally intended for Black residents. These frustrations are often illustratedn local media accounts. A 2006 *Washington Times* article captured some of these thoughts from Black citizens:

> [I]llegal aliens are 'flooding' historically Black neighborhoods without assimilating, and taking advantage of overburdened government resources such as public education and health care… We have no opportunity to provide services [to Blacks] when the first people who get in line are people who don't belong here…Come here legally and you can get in line and get anything you want. But when you come here with the direct desire to take from me ... we have a problem (Summers 2006).

In North Carolina, news reports call attention to the existence of a "fear of a brown planet," and stereotypes such as: "most mexicanos don't practice birth control, they have litters of babies" (WRAL.com 2005). In California, nearly fifty percent of Blacks supported

Proposition 187 (a 1994 policy designed to deny public services to undocumented immigrants). A 2006 Pew Research Center survey found that more Blacks (33%) see immigrants as taking away jobs from US citizens than do either whites (25%) or Hispanics (9%). Of those Blacks surveyed, 54% said that undocumented immigrants should not be eligible for social services provided by state or local governments, and 21% said that the children of undocumented immigrants should not be allowed to attend public schools. The same survey found that seventy-five percent of Blacks said that increased immigration has led to difficulties in finding a job, and twenty-two percent of Blacks responded that they or a relative had lost a job to an immigrant. Hutchinson (2006a) notes:

> The Minutemen's pitch to Blacks is a shrewd, cynical ploy to capitalize on the split among Blacks over illegal immigration…An April Field Poll in California found that Blacks, by a bigger percent than whites and even American-born Latinos, back liberal immigration reform. But many Blacks express views that are wildly at odds with...the polls. Black callers have singed the phone lines at Black radio talk shows with anti-immigrant tirades. They bombard Black newspapers with letters blasting illegal immigrants. They complain that Latinos are hostile, even racist, toward Blacks.

Warranted or not, racial tensions between Black and Latina/o communities exist; and Care Inc., the community health clinic where I did participant observation for a year and a half, was no exception. Larger social and economic forces such as globalization (e.g., jobs moving overseas), the declining manufacturing sector, and shrinking state provisions for welfare and social services are partly to blame for the erosion of gains within the Black community, but these appear distant and abstract to actors in their immediate environment. Local community members are more likely to highlight first hand accounts of Latinas/os moving into their neighborhoods and using community resources.

From 1990-2000, the Latino population in NC grew by almost 400%. During this same period, anti- Latina/o sentiment grew substantially among Black (and white) North

Carolinians (Hemming et al. 2001; Hyde and Leiter, 2000[7],[8]). Care Inc. was originally created to meet the health care needs of the most underserved members of the local community. At the time (1970), this meant the Black community (approximately 80% of clientele). The clinic is (still) located in a predominantly Black section of town. However, by 2002, Care Inc.'s client base had become predominantly Latina/o (57%). By 2003, the proportion of Latina and Latino clients increased an additional 10%[9]. The clinic administration responded by hiring additional bilingual staff, mostly Latinas.

Given the perception of Black-Latina/o competition in the broader community, it is not surprising that the Black staff resisted the racial transformation of the staff and clientele. These changes threatened their own status. They responded by complaining that Latinas/os are "taking over" the clinic. They appropriated anti-immigration rhetorics of Latinas/os as those out to steal U.S. jobs, irresponsible breeders, and leeches off the welfare state.

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[7] When North Carolinians (Blacks and whites) were asked in 1996 about the increase of the Latina/o population in North Carolina (from 1.2 percent in 1990 to almost 3 percent in 2000) 2 out of 5 respondents said they were unhappy about it and that growth was a problem. When asked if they would like it if Hispanics moved into their neighborhoods, two thirds said they would not, and more than 90% said they would dislike having Hispanics as neighbors.

[8] A 2006 Pew Research Center survey found that a quarter of Raleigh-Durham residents (26%) cite immigration as a 'very big' local problem, slightly more than the national average (21%). And more than a third (36%) say that recent immigrants have had a negative effect on government services, compared with 26% nationally. In Raleigh-Durham, about two-thirds (67%) says illegal immigrants should not be eligible for social services. Some 62% of Raleigh-Durham residents say that recent immigrants do not pay their share of taxes.

[9] Since 1990 some southern states, including North Carolina, have become common destinations for Latina/o immigrants. According to the U.S. Census Bureau, North Carolina's Latina/o population grew 394 percent since 1990. According to census figures, Latinas/os account for 4.7 percent of the state's population. The rapid growth of the state's Latina/o population outpaced its growth nationwide, where the Latina/o population increased almost 60 percent. (Source U.S. Census Bureau. (http://quickfacts.census.gov/qfd/states/37000.html.)

Ironically, these rhetorics were not of their own making. They were created long before the rise of Latina/o immigration in North Carolina. In fact, they were the same stereotypes that white elites have used to label Black men as a "problem" (DuBois 1903; Collins 2004) and Black women as "welfare queens."[10]

Latina staff, in turn, maligned Black women for being "racist," "bossy," and "uppity." Latina staff said the Black women on staff were often "ungrateful" for the English-Spanish translation services they provided (that doubled their work load). The Latinas also argued that Black women were disproportionately influential inside and outside the clinic. They did not recognize, however, the extent of white racism against Black people in the U.S.

If the clinic had unlimited resources to hire additional staff, so job competition was not so fierce, and enough facilities to allow all patients to see doctors whenever they wanted for however they wanted, the racial conflicts amongst the staff may have looked very different.

The clinic's resources, however, were limited. In this environment, Blacks and Latinas/os used stereotypes to define what women of color are, and are not (and implicitly,

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[10] Black women's bodies and sexuality are depicted as tainted in welfare "reform" debates (Roberts 2002:61-62; Collins [1990] 2000; Jewell 1998; Rose 2003). Black women are regarded as sexually irresponsible, "hot-blooded," and "bootylicious" (Collins 2004: 27). As Collins (2004) explains, "the thinking …is that unregulated sexuality results in unplanned for, unwanted, and poorly raised children" (130). In turn, Black mothers are thought of as benefiting undeservedly from government aid (Clawson and Trice 2000; Gilens 1996, 1999; Levenstein 2000; Solinger 2000; Williams 1995). Many politicians, policy makers, and others claim that Black mothers should be punished for their situation (Adair 2000). Ronald Reagan characterized "welfare queens" as Cadillac-driving government cheaters and swindlers (*New York Times*, February 15, 1976 at A51), further demonizing Black women and girls (Jewell 1998:21; Roberts 1997:110-12). In 1995, Representative Mica (R-Fla) held up a sign on the House floor that read "Do not feed the alligators. We post this warning because unnatural feeding and artificial care create dependency" (*Congressional Record*, 1995 H3766 16; See Douglas 1995). Representative Cutin (R-Wyo.) characterized welfare recipients as "wolves" who eat their young; they have lost their ability to scavenge in the wild (*Congressional Record,* 1995 H3772 4; See Douglas 1995). Similarly, in 1994, Governor Weld (R-Ma.) used a story of child abuse in Boston to "demonstrate" how unfit welfare recipients use their children to increase their welfare checks (Gillian, 1995).

what white women are and are not). As Collins ([1990] 2000) notes, the goal of these images is "not to reflect or represent a reality but to function as a disguise, or mystification, of objective social relations" (68). These images, constructed by white elites, "possess the power to legitimate [the controlling images]…as being universal, normative, and ideal" (68).

The U.S. has a rich history of whites using rhetoric to define and oppress Blacks. At Care Inc., however, these "controlling images" were employed by the low-status staff upon <u>each other</u>. A purely Black/white framework does not accurately reflect what happened. As Williams and Correa (2003) caution:

> We have noted the emphasis given by sociologists (including many symbolic interactionists) to Black-white relationships and the fact that this will need to be changed. It is necessary to take account of a much broader range of minorities. We have come to a point in history wherein a wide variety of minorities—Native Americans, Asians, Hispanics, and others—demand attention, as they live and work within the same communities as members of the dominant group (758-759).

In this chapter, I analyze how relationships between two minority groups, "themselves affected by the dominant sector's actions toward different minorities" (Williams and Correa (2003:759), played out in interaction among staff members and between staff and clients at Care Inc. Specifically, I analyze the rhetorical strategies Black and Latina staff used to preserve or enhance their status, and how these rhetorical strategies accentuated and perpetuated differences (real or not) between Latinas/os and Blacks. These rhetorical strategies, ultimately, have consequences. They require racial groups to enforce solidarity and justify withholding services to out-group members. Also, in the absence of positive, alternative rhetorics, efforts to explore avenues of solidarity based on shared interests are undermined.

METHODS

I was both a participant observer and a volunteer at Care Inc. As a volunteer I "floated" through four of the six units. A Colombian graduate student in the U.S., I am fluent in both Spanish and English and translated as part of my volunteer work. I observed and worked with the staff at the front desk, the maternity care coordination program, the WIC and Nutrition department, and the clinical unit. For example, I worked as a receptionist at the front desk and as a client care coordinator. I registered clients and searched for medical records. In the clinic I translated for clients while I observed the medical assistants, nurses, and clinicians in action. The activities of a volunteer were well suited to the job of observer. I hung around without being in the way, listened to and participated in conversations with staff and clients, and watched their daily routines. In the year and a half that I did fieldwork (May 2002 to December 2003) I visited the clinic three days a week for five to six hours a day.

This study is grounded in the symbolic interactionist perspective in sociology (Blumer, 1969[11]). I also used the approach of grounded theory (Charmaz 2000). As an interactionist, I studied staff's understandings of themselves and others. I focused on patterned interactions between staff and clients that sustained or challenged inequality (Schwalbe et al. 2000). As a critical feminist (Frye 1983; Bartky 1990) I explored issues of power in contemporary racial/ethnic and gender hierarchies, with a commitment to challenging these hierarchies. These theoretical and political commitments informed my fieldwork and analyses.

[11] My study is also multicultural in that it acknowledges that women, depending on their race, ethnicity, class, sexual preference, age, religion, educational attainment, occupation, marital status, health status, etc., experience oppression differently. It is also global in that it recognizes that women experience oppression differently depending on whether they are a citizen of a First or Third World nation (Tong 1998: 212).

After each day at Care Inc. I wrote detailed field notes. I began analyzing the data by writing notes-on-notes (Kleinman and Copp 1993), then analytic memos (Lofland and Lofland 1995). Collecting and analyzing the data simultaneously allowed me to test my explanations and modify my interview guide. I interviewed 21 of the 40 employees, including employees who worked at the front desk (center manager, reception, registration, client care coordination [referrals], billing, and medical records), clinical area (triage nurse, regular nurses, laboratory technicians, and clinicians), Maternal Care Coordination program, and WIC and Nutrition Department. Of those interviewed, five were Black and six were Latina. I also collected documents produced and/or used by the health care providers, as well as flyers and brochures available to the clients. These provided additional sources of data about health care work.

SETTING

Low-status workers, all of whom were African-Americans and Latinas, divided themselves along racial lines. The tensions became so intense that administrators and clinicians eventually organized a cultural diversity session, led by a Latina and a Black woman (discussed in Chapter 3).

Of the 40 employees at Care Inc., 13 were white, 14 were Black, and 12 were Latinas. Ninety-five percent of the employees were women; only two men worked at the clinic during my fieldwork. One was a clinician; the other worked as the Woman, Infant and Children (WIC)[12] administrator. Although the racial composition seemed balanced at Care Inc., the

[12] The Woman, Infant and Children (WIC) program provides supplemental food package—in the form of vouchers—to pregnant, post-partum (up to 6 months), and breastfeeding women

most powerful positions were held by whites: they were the clinicians, the directors of all the units, and the center manager. There were exceptions, however: the executive director, who worked off-site, was a Black man; there was a Black female physician (who worked two days a week and left the clinic to work in private practice in December 2003). The lead nurse was also a Black woman. The Maternity Care Coordinators (MCCs)—two Latinas and two whites—occupied a mid-level status. Most of the Black staff occupied low-status positions, including receptionist, medical assistant, laboratory technician, WIC/Nutrition Department coordinator, and nutritionist. Most of the Latinas also occupied low-status positions: receptionist, client care coordinator, medical assistant, laboratory technician, WIC administrative assistant, and pharmacy assistant.

Founded in the early 1970s, Care Inc. provided comprehensive health care services and education to mostly low-income people. In the mid-1970s, Care Inc. served primarily an African American community. As of 2002, Care Inc. served mainly Latinas/os. As stated earlier, the changing demographics at the clinic reflect the fact that North Carolina has recently seen a high rate of Latina/o immigration to the U.S. Black female staff interpreted these demographic changes as evidence that Latinas/os were "taking over" the clinic, and that Black people's interests and needs were no longer a priority because the "clinic is catering to Latinas/os."

As Care Inc.'s clientele changed, clinic administrators hired bilingual workers to replace departing staff. Most new staff were Latinas (95%) who spoke Spanish and English (and

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(up to 1 year), and infants and children up to their fifth birthday. They must meet financial eligibility (below poverty level) and be at medical/nutritional risk.

were willing to take a low-paying job at a community clinic).[13] Black female staff felt threatened by this situation. For example, six of them said to me on separate occasions: "I can't understand many of the clients who come into the clinic and so I feel unable to help those clients. I feel that my Spanish speaking co-workers perceive me as useless"; "In situations where my co-workers are discussing problems in Spanish, I feel frustrated by the thought that I could be useful if only I understood/if they spoke English"; "I feel I wouldn't be hired at this company right now because I don't speak Spanish. This makes me feel even more useless"; "I feel excluded from groups of Spanish speaking co-workers"; "I feel insulted when people speak a language I can't understand in front of me; I feel like they are talking about me. I feel disrespected"; and "The presence of a staff that is mostly bilingual and the decision to hire bilingual people as often as possible has led to a clinic that is welcoming to Hispanics but can be perceived as pushing away other target people. I miss the old client population at the clinic—my friends and family used to come here and now they do not." Not being able to identify or effectively communicate with their new clientele, these black women searched for ways to make sense of, and respond to, their declining status.

BLACK WOMEN'S RACIAL AND GENDERED RHETORICS ABOUT LATINAS

The Black staff viewed the Latina/o population as driving away Black clients and making Spanish the primary language spoken at Care Inc. They responded with the cultural

[13] A recently hired entering Medical Assistant I was paid $17,200 a year and a Medical Assistant II received $18,900. A Licensed Practical Nurse was paid between $19,700 and $28,700. Maternity Care Coordinators were paid $26,000 a year, and the Registered Nurse, $31,000. At the higher end of the pay scale were the physicians, paid, on average, $48,500. Many low-status staff had a night job they went to after working at the clinic, and others had a weekend job. Staff's second jobs were also in health care: they worked at local nursing homes as nurses' aides or at a local hospital as medical assistants.

tools immediately available to them: racialized and gendered rhetorics that they used to define and control Latina staff and clients. As Margaret, the Black receptionist said to me when I was helping out at the reception desk: “they have now what we worked so hard for” (Fieldnotes). Black staff dealt with the fear of losing what little social and occupational status they had gained by labeling Latina staff as lazy and incompetent workers who lowered the clinic’s status and respectability. They criticized Latina clients for being bad mothers, blamed Latina/o clients for “working the system,” and labeled them as irresponsible care-seekers who were undeserving of subsidized health care in the U.S. These images were familiar because they were the same ones that white elites have used (and continue to use) to constrain Black women. However, by recycling these rhetorics, they also legitimated their use.

Lazy Latinas

Black staff defined Latina staff as “lazy.” As Margaret, the Black receptionist, said: “[Latina staff] have not been able, or willing, as some are saying, to get the job done.” Five Black staff members described Latina staff as troublemakers and “whiners” who constantly complained about their workload.

Margaret said in an interview:

> I think the company doesn’t hire a lot of people with good work ethics. You know what I’m saying? To me, anything goes here. This place is too laid back…I mean, you know, if there are rules, then they need to be abided by. Here it just seems to me, and I know there are rules and regulations, but it just doesn’t seem they are enforced. I think as far as like going on extended vacation, like a month or two because they’re going out of the country, to their country, and their position is not replaced. That’s hard on the person that’s still here.

The Black staff were frustrated by a workplace strategy the Latina staff saw as their only option to visit home. The Latina staff accrued vacation time and extended it by taking sick leave and planning their trips near holidays. Traveling to their home country was costly and time consuming. These long vacations, however, made work difficult for the remaining workers at the understaffed clinic. However, Margaret focused the blame only on the Latina staff, not the center manager or administrators who approved these vacation arrangements.

The Black women on staff were also frustrated by the speed of the Latina workers. The senior Black medical assistant felt she needed to prod the Latina staff constantly:

> Eva: The hardest thing is when my co-workers are not doing their 100%, not giving their all. And that happens when I'm working and working and working and working, trying to do ten million things and it's just impossible and your co-workers are not pitching in. That's pretty bad.
>
> Natalia: How do you deal with that?
>
> Eva: I am the lead medical assistant there, and so, my thing, which they don't like, I don't not stay on them but I do kind of remind, you know, that this is what they're supposed to do, you know: "trabajen [work] rapido [fast]." You know? I have to remind them that if they're going to work here we got to work together. This is the only way it's going to work, is together. (Interview)

Eva implies that Latinas are choosing not to work fast enough: only a "lazy" worker needs to be reminded to keep up. By prompting co-workers to work faster in broken Spanish, Eva implies that Latinas are the lazy, ineffective workers at Care Inc. Similarly, Genesis (a Black medical assistant) and Desiree (the Black lead nurse) criticized the Latina medical assistants, Gladyz and Bibiana, who worked with them in the clinical area. I often heard Genesis commenting to Desiree that "Gladyz is very slow. Very slow! She doesn't do what she is supposed to do." It is worth noting that Gladyz, a recently hired medical assistant, was supposed to be trained by Desiree (the Black lead nurse) or Genesis (a Black

medical assistant). However, after working for six months at Care Inc., Gladyz had not been trained to do all the procedures she was expected to do. Even so, Desiree and Genesis put the onus on Gladyz, thus excusing themselves from training her. Ironically, it is Blacks who have been historically stereotyped as lazy and unproductive in the U.S. when they were systematically denied the resources to succeed.

Not all Latinas were labeled lazy, however. They treated me, as well as high-status Latina staff in another clinic department (e.g., the Maternity Care Coordinators) in a friendly and cordial manner. They praised us for our "hard work" and "dedication." Margaret told me:

> You have been a blessing yourself this year, don't laugh, all over the clinic. I never once…whenever I ask you to…you know call you on the intercom. "Can you do so and so?" Never once did I hear, "No, I'm busy". I mean you're always willing. And that's the kind of people they need to make things flow. (Interview)

The MCCs and I, however, all shared a common trait: a higher social class. We had educational credentials, were fluent in English, and had assimilated U.S. cultural norms. Our jobs were "easier" because we had the tools to accomplish them. Our success also confirmed their characterization of "laziness" as a personal choice: one could choose to work hard, or not. We were the "hard-working" <u>exceptions</u> that proved the "lazy" rule. We showed the Black staff that Latinas/os, if they wanted to, could work harder, be dedicated, become assimilated, speak English, etc.

Further, the MCCs and I did not threaten the Black staff's social and economic status. As a Ph.D. student and volunteer, I did not put their jobs in jeopardy. Rather, by being a Spanish-English translator, I was a help, not a threat, to their jobs. The Latina MCCs also did not compete for the Black workers' jobs; all had graduated from a four-year college and a

couple had a graduate degree. As MCCs, they had the education and training that put them in a different occupational category than the lower-level Black staff.

Bad Mothers and Unruly Children

Black staff also demeaned Latina staff by characterizing Latina clients as "bad mothers." Again, like "laziness," the "bad mother" cultural symbol has been applied by white elites to blame crime, teenage pregnancy, and poverty in Black communities on poor parenting skills (Kaplan 1998; Solinger 2000; Roberts 1997, 2002).

Black staff, as well as Black clients, constantly asserted that Latina clients must learn to teach their children to be quiet and sit still. For almost two weeks, Margaret (a Black woman who did not speak Spanish) and I worked as the clinic receptionists. She hushed Latina/o children running around the waiting area with a loud and angry "SHHHHHH!" If the child did not stop she would order the mother (or caretaker): "She/he is going to have to go." She barked and gestured roughly at clients. At first I thought she behaved this way with all the clients, but then I noticed that her demeanor changed when the clients were Black. As I wrote in my fieldnotes:

> Margaret seems to know the name of most of the Black people that come in. She also seems to be very friendly and willing (and able) to strike up conversations with them. "Hello so-and-so, how are you doing today?" "I like that top you are wearing." "You went where for lunch? Did you get their biscuits?" "Hello darling, how can I help you today?" However, with some whites and most Latinas/os she is rough, tough, impersonal, and cold. She seems not to know whites' or Latinas/os' names, and never calls them "sweetie," "darling," or "handsome" as she does with Black clients. To a Latino, for example, she barked "Need help?" When he did not reply she asked again, "Hey, need help?" She rolled her eyes and her voice became louder as she repeated herself. After the third time she said to me, "Natalia, check what is wrong with him."

Margaret also complained constantly about the noise the Latina/o children in the clinic made, saying, "Don't they know this is not a playground? They are driving me crazy!" On one occasion she remarked about three Latino five year-olds, "Don't they go to school? You just see them so often that you start to wonder what they do all day."

When I interviewed Margaret, she said:

> The clinic is supposed to be for everybody. I guess that over the years, people, Black and white clients, I mean, have just decided to go elsewhere because of the noise. It is a lot of children... Hispanics, is what I am speaking of, if one has an appointment you might see three or four people with them. There are not enough chairs to sit. There's a lot of noise. I've heard other clients say that, you know, they complain because there's not enough room, there's not enough chairs to sit, or there is too much noise in the waiting room and when you have older clients they don't want to hear all that noise and I can relate to that. If you're here and you're sick, you definitely don't want to hear it… Mom or dad has an appointment, you bring all the kids. School is open, your kid is here translating for you, missing school, and I don't know…I guess because I've never seen that before until I started working here. Maybe it's allowed. It wouldn't be allowed with any of *my* children.

Here we see that Latina/o parents, and their misbehaving children, are cited as the reason why Black community members no longer visit the clinic. I often observed many Latina clients bring their children and other family members to the clinic when they came to see a clinician. Sometimes, Latinas would bring their older children along so that they could translate, watch the younger children during the parent's appointment, or take a younger child in for her/his appointment. Mothers brought their children because they were responsible for taking care of them and did not have anyone with whom they could leave them. Many Latina clients did not have extended family living in North Carolina (or in the U.S.). Again, Margaret described being a "bad mother" as a personal flaw unique to Latinas/os instead of a function of unaffordable child care options and limited translation services.

Margaret defined herself–and Blacks as a group—as different and better than Latinas by emphasizing the differences (real or not) in parenting skills between Blacks and Latinas. She used *defensive othering,* a process by which one marginalized group constructs boundaries between itself and other marginalized groups, while at the same time defining its members as morally superior to these marginalized out-groups (Schwalbe et al., 2000).

It was also common for Stephanie, the Black triage nurse, to comment on Latinas' parenting. Latinos (the men) were rarely judged for their parenting abilities. On one occasion, Margaret shushed some Latina/o children who were laughing in the waiting room. She said to Stephanie and me, "I've got to fuss all day at these kids. They have no home training…. Jesus!" On another occasion, Stephanie said to Margaret, in reference to some Latina/o children who were playing with a newspaper, "Where are these kids' mothers? We would never let our children behave like this." The "we," it seemed, were Black women. I recorded the following conversation between Stephanie and Margaret. Stephanie said:

> A lot of children…come into the clinic. That's fine. But to me the parents don't have any control of their children. They don't seem to discipline their children. I mean that's just my opinion. Because I see the kids doing things to their parents that I wouldn't allow; hitting them, or pulling them, telling them to stop, or no, or whatever. And there are certain places you go that children should be able to at least try to act, you know, good, or the parents should discipline them a little more as far as finding a way of keeping them quiet, some kind of way. I think that's a problem. And then I guess there are so many children that come in for WIC, for appointments, for walk-ins.

Most of the "parents" that Stephanie criticized were mothers who had brought their children with them to the clinic, as they needed to be seen by a clinician, the WIC nutritionist, an MCC or other staff person at the clinic. What Margaret and Stephanie defined as uncontrollable and undisciplined children, Latina/o parents viewed as healthy, energetic, and happy children who were behaving as children should. Because other children were at

the clinic, Latina/o parents encouraged their children to play with them. If a child did not want to play or was "lethargic," Latina/o parents would take that as a sign that they were sick or coming down with something. As a Latina mother mentioned to me after being reprimanded by Stephanie:

Que tiene ella contra mis hijos? A Dios gracias de que ellos están bien, contentos y corriendo. No como yo, con gripa y dolor en todo el cuerpo. Si niños se ríen o gritan, ella nos regaña. Cualquier ruidito la pone de mal humor.	What does she have against my children? Thank God they are healthy, happy, and running around. Not like me, with a cold and pain all over my body. If children laugh or shout, she scolds us. Any noise puts her in a bad mood (Fieldnotes).

Stephanie and Margaret did complain, on occasion, about the noise of Black and white children. But they rarely said anything to the Black or white parents, especially the mothers. And, I never heard them label these mothers as bad. As I wrote in my fieldnotes:

> A Black woman, about 30 years old, came into the clinic today. She was first in the reception area, while waiting for her prescription to be filled, and then she came to the WIC office. Her 5 children accompanied her. Their ages were 5, 4, 3, 2, and less than 1. Four of the children were girls. The children were loud. While at reception and in the WIC office I observed the children fighting, running around the offices, picking up pencils or paper on the desks, and dropping their jackets in the middle of the room…. The baby came to the desk where I was sitting, and started opening the drawers. The children shouted, and the mother shouted at them, once in a while, to be quiet. Yet, as the mother asked for silence, the children seemed to do just the opposite: cry, shout, or pull one of their siblings' hair to make her/him cry…. Stephanie said nothing to them when they were in the reception waiting room. No one at WIC said anything to them, either. But when the family left, Richard, the only Black staff at WIC, called Stephanie and said: "Just called to tell you that [she] was gone. They nearly tore up the place. I worked as fast as I could to get them out of here."

The Black staff did not regard this family as representative of Black families. In fact, they seemed to silently rally to get this mother out the clinic doors without criticism. This stood in counterpoint to the way Latinas were confronted and criticized about their "unruly" children. After complaining to the mothers, Stephanie and Margaret typically commented

that Latina mothers should do a better job of controlling their numerous children. However, they rarely complained or said anything to the Black mothers. And white mothers seemed beyond critique. Cultural definitions of what constitutes "healthy" behavior will vary. At Care Inc., however, these differences were accentuated and associated with racialized and gendered rhetorics that described Latinas as bad mothers. This cultural imagery fits seamlessly with prevailing explanations of why people of color experience high rates of crime, poverty, unemployment, etc. It places the blame on them and the way they behave (not the structural conditions that limit their opportunities).

Margaret was comfortable with the Black people who came into the clinic. She knew their names, complimented the women by saying things like, "what a nice dress you have on today, and perfect for this weather." She usually greeted them warmly and talked and laughed with them for a while. This stood in marked contrast to her interactions with whites and Latina/os. A possible explanation for her familiarity with the Black clients might be that she knew Black clients from her neighborhood, church, or another community organization. However, Margaret had recently moved from New York to North Carolina, and told me that she didn't know many people. Even if they weren't personal acquaintances, Black clients increased her comfort and value within the clinic. Without Black clientele, perhaps she wouldn't be needed in the job.

In the U.S., motherhood is romanticized and media portrayals "seem on the surface to celebrate motherhood, but in reality promulgate standards of perfection that are beyond… reach" (Douglas and Michaels 2004:4-5). The media promote a white, middle-class ideal of motherhood that is difficult for any mother to live up to (see Hays 1998); it is especially hard for poor women and women of color, who endure extra scrutiny and have few resources.

The women who fail to meet these idealized standards are blamed “for being horrible rather than only human” (Caplan 1998:127). Blaming individual mothers also negates the need to discuss why (and under what conditions) some mothers are “good.”

Abusing the system

Black staff put down Latinas by saying that they “worked the system,” especially the health care system, and, were undeserving of services. Some of the behaviors Black staff found acceptable for Black clients they found unacceptable for Latina/o clients. For example when I was translating for Stephanie, the triage nurse:

> A Black man and his teenage son came into Stephanie’s office, asking to be seen by the doctor. They did not sit down, and when talking to Stephanie they did not look at her. When Stephanie asked for some details (i.e., how long the son had been sick, what was his temperature, etc.) the father rolled his eyes and sighed. Stephanie, although she did not get a response from him, did not ask twice, and wrote a note that allowed them to be seen by a doctor…

Later that day,

> A Latina came into Stephanie’s office with her two sons. She said to Stephanie, “Mi hijo esta enfermo, ha tenido fiebre y no esta comiendo [My son is sick, he has had a fever and he has not been eating.”] The mother did not sit down, as she was carrying the boy, and holding on to the second son with her left hand. Stephanie asked “Cuanto temperatura? [How much temperature?]” The mother replied, “No se! [I do not know!]” Stephanie rolled her eyes, took her hand to the boy’s forehead, and said, “El bien. No fiebre. [He is OK, he has no fever.] The mother and two sons walked out.

The Black father was rude to Stephanie , but she did not comment on it, and let the man and his son see a doctor. The Latina mother attempted to communicate her distress to Stephanie, but Stephanie rolled her eyes and did not fill out the form to give permission for them to see a doctor. To Stephanie, Latinas were rude and uncooperative. She also maintained that Latinas/os feigned symptoms, or made their children feign symptoms, so that

they would be seen by a clinician. Prevailing racialized and gendered rhetorics explaining Latina behavior (in this case: they abuse social services) helped Stephanie make sense of why the boy was brought to the clinic and why it was okay to deny the child access to the doctor.

When Stephanie treated Black female clients she was cordial and friendly. A Black client's visit with Stephanie often lasted twice as long as a Latina's or Latino's visit with her. When asking about symptoms, Stephanie never challenged Black patients' accounts, as she did with Latina/o clients, and I never observed her deny a Black family access to medical care. She often commented to me, after a visit from a Black client, that Blacks were fairly absent from the clinic because "they were driven away."

Black staff often complained about giving health care services to Latinas/os. Margaret, a receptionist, complained about the "misuse" of the health care system by the Hispanic clients. She said:

> I mean sometimes it seems like some of the things they're coming in for they could remedy at home or figure it out yourself. Lord knows, if I came to the doctor every time I didn't feel good…Especially, you know, allergies, your throat's sore, or whatever. It's allergies....and I mean. We just seem to see a lot of clients …well, to me it seems like that … they come here also because they're not paying. They're not paying because we're one of the few that offer a sliding fee scale, so you pay whatever that scale is. Or if you don't have any money, you have seen the doctor, you were here last week, it was the same thing. And that's allowed.…You know, it makes you think, well, I bet if they went to, what I call a regular doctor's office and they did not offer a sliding fee scale, and they may have to pay that money, I mean, you know, some of these things they come in for, they wouldn't.

Margaret made it clear that she, and by implication other Blacks, would not go to a clinician for trivial matters. She assumed that Black clients are more discerning than Latina/o clients; they knew when to use the clinic and when not to. The rhetoric of "abusing the system" has been used in the past to deny Black women ("welfare queens") social

services as well. In both cases, it allows service providers a rationale for interpreting an action (visiting the clinic) as inspired by greed instead of need.

Other Black staff also criticized Latinas/os' use of the community clinic. Eva, the Black medical assistant, said:

> We're just so overwhelmed. It's a long day and you're overwhelmed with clients. They sit at home and they can't wait for Monday morning and they sit out there, sometimes out in the freezing cold waiting on the clinic to open. I get to work at 7:30, and I'm not lying, clients will be sitting outside wrapped in blankets waiting on the clinic to open, to come in the clinic. I don't understand it. I really don't understand it. And then some come, and I don't know if they use it for their little way of getting out to meet their friends or whatever, a lot of clients will come and spend the day.…I don't know what they use the clinic for.
>
> Natalia: Are these clients mostly Latinas and Latinos, or mostly African-American or white clients?
>
> Eva: Oh, no, I mean Hispanics. They are the ones who come here, stay all day long, and meet their friends. The other clients come and leave after they're done.

Indeed, many Latina/o clients did meet other Latinas/os at the clinic. Latinas/os would often catch up and talk while waiting to see a clinician or pick up a prescription. The Latina/o clients that "stayed all day long" usually had several appointments at the clinic. It was not unusual for a Latina client to bring two of her children to see a clinician, visit a maternity care coordinator, pick up formula from the WIC office and medicine from the pharmacy, all in the same day. Many Latina/o clients preferred to do everything in a day, they told me, because childcare, transportation to and from the clinic, and taking a day off from work were costly and sometimes impossible.

Many Black staff thought of Latina/o clients as "getting something for nothing" (Stephanie). In their view, the clinic was "bending over backwards to serve Hispanics" (Eva). Blacks' resentment toward Latinas/os was evident when they complained to me that

Latinas/os were abusing the system by refusing to learn English and yet still expecting to receive adequate service. For example, Margaret, the clinic receptionist, said the following when I asked her if she had ever thought of learning Spanish:

> Well I just feel like…You know, to me the Hispanics need to learn more English, rather than, you know, I'm expected to learn Spanish, because if they choose to live in a country where obviously the language is different, then I just feel like one should learn it. If I was to go to Europe, or wherever, to live, I need to learn that language…. But I have learned certain things, I have. And I think I do, I think I do pretty well as far as making out appointments. But, I will say this, I find if there is no one around me that speaks Spanish, if there is no translator, they can spit out a little English, enough for me to figure out what they need.
>
> Natalia: What do you mean? Can you give me an example?
>
> Margaret: When they're forced to, and the same thing with the telephone. I've learned if there is no one around at all, and sometimes there is no translator, I've learned to say that… [the Spanish speaking receptionist] is at lunch, comiendo. What is it, esta comiendo?
>
> Natalia: Esta comiendo, yes.
>
> Margaret: Yeah, esta comiendo. And they say 'okay' and hang up. Or if I say, "Do you speak any English," many say "a little." And I just say "no translator" and then I tell them to explain what they need. And sometimes they can. But I find that if they're forced to, because there's no one around, we can work it out. (Interview)

Margaret implies that Latina/o clients knew at least a bit more English than they let on. This was not the first time I heard the Black staff complain that Latinas/os were not learning English (or pretending not to know). When I was translating for Desiree, the Black lead nurse, she often asked me why "your people" would do things that were "just not right." From my fieldnotes:

> Desiree: Natalia, one of the greatest complaints I hear is: Why don't Hispanics learn English? It is a two-way thing. I have learned Spanish, well, a little, why don't they learn English? They have children who speak English, they have been here for years, but they don't learn English. …

> Natalia: (purposely not answering the question) Where have you learned Spanish?
>
> Desiree: Here at work. I have learned it here.
>
> Natalia: Have you gone to a class?
>
> Desiree: Oh no. I am too busy with work, church, and family. I have no time. I would feel guilty if I have to leave to go to a class…

Desiree implied that she, and by implication other Blacks, would act differently toward Hispanics if they learned English. For Desiree, Latinas/os—despite working two or more jobs, working weekdays and weekends, having difficulties with transportation and childcare—had no excuses for not learning English. It is understandable that Desiree did not learn Spanish; she was overworked and had little free time. In addition, the administrators did not give her time off or pay for her to take Spanish classes. The combination of poor English skills with preconceived notions that Latinas/os are "lazy" and "abusing the system" provides an ideal situation for a group trait (language skills) to be attributed to a personal failing (instead of a product of limited time, money, and language classes).

Black staff, then, used preexisting racist and sexist rhetoric to discredit Latinas as lazy, working the system, having no regard for rules and discipline, and being bad and irresponsible parents. These stereotypes allow structural inequality to go unexamined and place responsibility on the disadvantaged themselves. However, by re-using these cultural symbols, these Black women breath life into cultural explanations that justify the existence of inequality.

As we shall see in the next section, the low-status Latina staff also relied on cultural images to frame the actions and behavior of their Black counterparts in a way that legitimized their own frustration, resentment, and resistance.

LATINAS' RACIAL AND GENDERED RHETORICS ABOUT BLACK WOMEN

Latinas too used race- and gender-coded rhetorics to respond to the Black women's typifications. At Care Inc., Latina and Black staff occupied low-status positions. However, because of seniority, Black staff trained and supervised Latina staff. Latina staff disliked this, as Amanda (a Latina client care coordinator) explained during a break:

> You know, like, what we're finding out lately, me and Tatiana [the Latina receptionist], is that, like the lady in the back [Diane, a Black woman in charge of medical records], obviously she's got way too much time on her hands, because she's constantly watching who's coming in, you know, who's leaving at what time. That's not her job. Like you know, she's got her job. Her job isn't like the supervisor where she's checking employees about who comes and who doesn't come and who stays and all this other stuff. So Margaret [Black receptionist] and her get together on this. And then they go ahead and call corporate, you know, call corporate to say, "Well, you know, this person didn't come or where is she?" (Fieldnotes)

Latina staff assumed that Black staff had more power and advantages than Latina staff. Latina staff criticized Black staff for being authoritarian and making more work for them by asking them to translate. Latina staff also argued that administrators cared more about Black staff's needs, and that Black clients had other options for jobs, health care, and other social services that Latina/o clients lacked because they were not U.S. citizens (unlike the Latina/o clientele). As a result, Latina staff claimed that Black women were more powerful both inside and outside of Care Inc.

At the clinic, all the white staff members spoke Spanish or were learning to speak Spanish. The only staff members who did not speak Spanish were Black: Stephanie (the triage nurse), Desiree (the lead nurse), Margaret (the receptionist), Diane and Penny (the two Black women in charge of medical records), and Eva and Genesis (the two Black medical assistants). The only Black person on staff who spoke Spanish was Dr. Sikes, who left the

clinic to work in private practice in December 2003. The Black staff were encouraged to take Spanish classes, but the administrators did not offer them time off to learn Spanish or reimbursement for classes. The white staff, on the other hand, had learned Spanish either during college or by taking an immersion and intensive Spanish course in a Central American country (at a personal expense of over $1,000 per week).

The Latinas did not recognize the systematic inequality the Black female staff (or Blacks in general) experienced on a daily basis. Instead, they questioned claims that the Black women were victims of racism because the Latina staff felt these Black women were racist themselves.

Seeing Black Staff as Racists

All the Latina staff members I talked to said that the Black staff were "racist." The Latina staff complained that they were victims of discrimination, or at the very least, were mistreated by the Black staff. Gladyz and Bibiana, the Latina medical assistants, often complained to each other (and to me) about the "racist comments" made by the Black medical assistants and nurses.

For example, Gladyz complained about Stephanie, the Black triage nurse, and Eva, a Black medical assistant, after the Black co-workers chastised Latina clients for abusing the U.S. health care system by coming to the clinic "too often." I wrote in my fieldnotes:

> Stephanie, who came into the nurses' station, said to Eva: "People can't be that sick." Eva replied: "I know what you mean….See that woman (Latina) with that plastic bag from Wal-Mart? She came in yesterday. I can't believe it. Why would they [the Latina and her son] bring that big plastic Spiderman balloon with them? Certain things are left at home." Stephanie said, "Don't they have anything better to do? We're not giving anything away here. Urghh, these people! "

Bibiana, standing by the nurses' station entrance door, then said: "they [Stephanie and Eva] are just ignorant and disrespectful people. Don't all people have the right to come to the clinic as many times as they feel they need to get medical care?" Gladyz nodded in agreement.

I observed instances in which Latina staff characterized Black staff's interaction with Latina/o clients as mistreatment. I wrote in my fieldnotes:

> Trish, the white women in charge of billing is at lunch and it is time for Tatiana, the Latina receptionist, to go home. Tatiana asks Diane, the Black woman in charge of medical records: "Diane, you know, I don't think Trish's coming back. Do you mind just staying on the window for an hour?" Diane agreed. When a Latina client asked Diane for something, she said: "I don't want to hear it!"

Amanda, a Latina Patient Care Coordinator, observed Diane's interaction with the Latina client. Amanda said to me:

> Well, Diane had to fuss over it. Like, if Tatiana would have asked me, I would have gladly said, "No problem…Do what you have to do." But when she [Diane] doesn't want to do it, she makes a fuss. She's racist, and she takes it out on the [Latina/o] clients. Her hands were going, and she was like, "I don't want to hear it!" The [Latina] client was just asking a question. But because she didn't want to be in the window, she took it out on the client. The client had nothing to do with it. (Fieldnotes)

On another occasion Tatiana, a Latina receptionist, complained to me about Margaret:

Tatiana: Me da rabia y lástima como Margaret trata a los pacientes Hispanos.	Tatiana: It makes me so upset and sad to see how Margaret treats the Hispanic clients.
Natalia: ¿Cómo trata Margaret a los pacientes?	Natalia: How does Margaret treat the clients?
Tatiana: Ella los trata mal. Es racista. Siempre les esta diciendo, "*No English? Can't help you.*"	Tatiana: She treats them badly. She is a racist. She is always saying to them, "No English? Can't help you."

Latina clients often complained to the Latina MCCs about the tone, comments, treatment, and/or service they received from "las morenas" (Black women). When I asked the Latina MCCs to describe some of the clients' complaints, MariaTe and Yolanda recalled what their clients had said: "Son tan bruscas [they are so rough]," "Me tratan peor que un animal, como si no fuera un humano [They treat me worse than an animal, as if I were not human]," and "No nos quieren aquí, y no les importa lo que nos pasa o le pasa a mis hijos [They do not want us here, and they do not care what happens to us or to my children]." What these low-status Latina staff did not discuss was how the Black staff's behavior might be a result of their fear of becoming irrelevant in an organization originally intended to serve "their" community.

MariaTe and Yolanda, the Latina MCCs, also said they frequently overheard Black staff and Black clients make snide remarks about Latina clients. They complained to each other (and to me) about the comments they overheard the Black women make: "Another pregnant woman? They breed like bunnies!" or "The first thing they [Latinas] do when they get here is get pregnant. They do it for citizenship." They also heard remarks about Latina staff members' accent and language: "I get a headache hearing Spanish," "I can't understand what they're laughing and joking about," and "I feel left out; I don't feel comfortable eating in the lunchroom." Latina staff claimed that their Black co-workers maligned them: "I feel ridiculed by my [Black] co-workers because of my accent," and "I feel disrespected; they [Black co-workers] are rude to me about my accent and about mispronouncing their names" (Interviews).

Some of the Black staff did not understand the Latina staff's complaints about them. Latina staff did not complain directly to the Black staff, but to the white high-status staff,

who then talked to the Black staff. After some Latina staff complained about Stephanie, she responded by saying to me, "I am Black, so how can I be racist? I have lived all my life with racism, and I *would never* be racist!"

On one level, Stephanie was right. Racism in the U.S. is a system that privileges whites over people of color (Tatum 2003; Wellman 1993). A white person who is not racist still has advantages in a racist society; she or he has unearned white advantages (Carbado 1999; McIntosh 1989). Some sociologists define racism as prejudice plus power: "racial prejudice when combined with social power—access to social, cultural, and economic resources and decision-making—leads to the institutionalization of racist policies and practices" (Tatum 2003:7-8). By these definitions of racism, Blacks, as members of an oppressed group, have little power to enforce their prejudices and thus cannot be racist. As a social system, racism requires the power to enforce discrimination and prejudice against others. And yet, by accusing the Black staff of being racist, the Latinas dismissed any notion that these Black women might also be victims.

On another level, however, Blacks (like whites) can be prejudiced and maintain that Latinas/os and other immigrant groups are inferior. If they enact these prejudices, Blacks (like whites) can discriminate against immigrants. Latinas/os are often targeted because they are not U.S. citizens. Latina/o immigrants are denied medical care and social services on a daily basis[14].

At Care Inc., the Black staff did not recognize their citizenship privilege (Schwalbe 2002), and the Latina staff minimized the way white racism in the U.S. shaped the Black

[14] Many U.S. citizens don't have health insurance either, but they are not denied access to health care because they are U.S. citizens. They might be denied medical care because they are women, poor, Black, or members of other oppressed groups in the U.S.

staff's lives. As a result, both groups exaggerated the other group's privileges. As we will see, this exaggeration of differences was made easier by prevailing stereotypes of Black women as argumentative and aggressive.

Pushy Black Women

Latina staff spoke of Black staff as pushy, uppity women. These racial stereotypes of Black women are also used by white elites to label Black women as "strong, bitchy women" (Collins 2004: 137). Collins (2004: 138) explains that labeling Black women as "difficult" is a way for white people to control poor and working-class Black women:

> Aggressive African American women create problems in the imperfectly desegregated post-civil rights era, because they are less likely to accept the terms of their subordination. In this context, Black "bitches" of all kind must be censured, especially those who complain about bad housing, poor schools, abusive partners, sexual harassment, as well as their own depiction in Black popular culture.

The Latina staff frequently told me that: "Black staff have not been able to work together with us and get the job done;" "they criticize us to the directors or supervisors;" and "they act like our bosses." When I worked with the receptionists, I wrote the following in my fieldnotes:

> Tatiana is the new Latina receptionist. Margaret is teaching her how to use the computers. Tatiana said "I know nothing about computers. I have years of not working on this, but I am going to give it all I've got." After Tatiana asked Margaret two or three times how something was done, Margaret said in an annoyed tone: "I already explained it to you once, Where're your notes?"

Margaret had little patience to train Tatiana and teach her to use the computer. Like any new employee, Tatiana's job would be in jeopardy if she did not learn how to do it. Without training, her efficiency suffered (making her subject to the accusation of being "lazy"). A few months later, I asked Tatiana, the Latina receptionist: "When you began working at the

clinic, what was the hardest part about it?" She replied that the hardest part was dealing with the negative comments from the Black receptionist as she was learning her job.

Because they were not bilingual, the Black lower-level staff relied on Latina staff to translate for them. This organizational set-up was a source of tension. Latina staff told me that Black staff "took advantage of them" and bossed them around. Tatiana, the Latina receptionist, explained:

Stephanie se cree mi jefa. Ella decía, "Ven a ayudarme a *translate*. *Can you hear me? Translate*." Yo quería decirle, "*Translate what? You don't even let people talk! So what do you want for me to translate?"*…Y cuando le preguntaron a Stephanie y a Margaret si querían aprender español, Margaret dijo: "*I'm not going to do extra. Because if they decide to come to a country where they don't speak, where people don't speak their language, it's their choice to pay the consequence."* Y empezaba a decir cosas feas.

Stephanie (the Black triage nurse) believes she is my boss. She says, "Come, help me translate. Can you hear me? Translate." I wanted to say to her, "Translate what? You don't even let people talk! So what do you want me to translate?"...and when they asked Stephanie and Margaret (Black receptionist) if they wanted to learn Spanish, Margaret said: "I'm not going to do extra. Because if they decide to come to a country where they don't speak, where people don't speak their language, it's their choice to pay the consequence." And she would start saying ugly things.

The Black staff treated translation not as a skill crucial to their work, but as a burden that Latina workers should have to deal with. It appears that the Black staff regarded translation as dirty work. This might have been a way for Black staff to protect themselves, since Care Inc. was not helping the Black staff learn Spanish. The Latinas possessed a unique and valuable skill. They resented its portrayal as a crutch for "lazy" people who preferred to "pay the consequence" rather than learn English.

Although Mariana, the Latina WIC assistant, worked in a different unit, she noticed the tensions between the Black and Latina staff at the front desk. In an interview, she discussed one reason why she disliked Margaret, the Black receptionist:

Esta Margaret, a veces me cae muy mal.

This Margaret, sometimes she gets to me.

Porque a veces está trabajando el *front desk* y esta Tatiana tiene tanta gente esperándola y este y el otro, y Margaret como burlándose dice, "*English? Spanish, spanish. There's nothing I can do.*" Y se pone a ver revistas, y se pone a limpiar sus lentes, y se pone a pintar los labios.	Because sometimes she is working in the front desk and Tatiana (Latina receptionist) has so many people waiting for her, and for this or that, and Margaret is making fun of it saying, "English? Spanish, Spanish. There's nothing I can do." And she starts reading magazines, and cleaning her lenses, and she paints her lips.

Latina staff often told me that Black staff treated other Black staff well, but bossed around the Latinas. During my fieldwork I too observed that Black staff interacted differently with other Black staff than with Latina staff. I wrote in my fieldnotes:

> As clients arrive, Eva (Black medical assistant) says to Gladyz and Bibiana (Latina medical assistants), "Are you hurrying? I am taking notes!" Meanwhile, Eva is seated, talking on the phone with her husband. A few minutes later, as Gladyz started to fill out some paperwork, Eva said to Gladyz, in front of a client: "Look at that paper, no, no, watch it, that is not the way it is done."

I never saw Eva hurry up Genesis, the other Black medical assistant. Eva only did this with the Latina medical assistants. I asked Gladyz, the Latina medical assistant, about this, and she said:

Gladyz: Ay. Yo te digo, yo no me voy con Eva. Eva ya yo, ¿cómo te digo? Ya aprendí a sobrellevarla…Eva es mandona. Te quiere mangonear, como si ya fuera la supervisora…. Y que si tú le dices, se pone como que una fiera, que mejor dicho, consigues una enemiga…. Pero yo me he dado cuenta de que eso es su manera de ser de ella. No, con Genesis no lo hace.	Gladyz: Ay. I'm telling you, I do not get along with Eva. I have learned to bear her. Eva is bossy. She wants to boss you around, as if she was your supervisor… And if you say anything to her, she gets fierce, in other words, you have gained an enemy… But I have realized that that is her way. …No, with Genesis she does not do it.

A few times Latina staff complained to the (higher level) white staff about the Black staff. Stephanie, the Black triage nurse, was eventually fired after Latina/o clients complained about her to the center manager, the lead clinician, and the Human Resource coordinator. The clients and the Latina staff were not listened to right away. It took several

months and frequent complaints from clients and Latina staff before she was reprimanded. Only after the director of an allied Hispanic organization documented the complaints he received about Care Inc. from Latina/o clients, was Stephanie asked to meet with the lead clinician and strongly encouraged to "change." Stephanie was fired only after she denied a (white) girl access to see a clinician, and the girl convulsed a few minutes later and was sent to a local hospital.

Latina staff asserted that Black staff had control over Latinas in this setting. However, Black staff were not the privileged members of Care Inc. Black staff members, like the Latina staff, were only trying to hold on to what status they had managed to gain. Black staff did have a better position structurally than Latina staff, but they were still structurally vulnerable within Care Inc. The most powerful positions were held by whites. Black women who did not speak or understand Spanish were, in fact, in jeopardy of losing their jobs. The Black staff also mentioned to me that if they were looking for a job at the clinic today, they would not be hired since they did not speak Spanish. They also told me that if a staff person had to be let go, it would most likely be a low-status, non-Spanish speaking staff member. And they were correct in believing that Latinas, who could speak Spanish, would be more likely to be hired than Blacks. Their fears were not unfounded.

It is worth noting that Latina staff, in labeling Black women as "problematic," failed to take Black women's oppression seriously. Latina staff failed to recognize how these Black women had limited power in and over their lives because of their position in economic and social hierarchies (Allan et al. 1993; Flynn and Fitzgibbon 1996). However, while perhaps understandable in context, the Black staff's adaptive strategies perpetuated Latina/o oppression and left the organizational and institutional conditions that created these racial

tensions intact. The rule of seniority (such as having Blacks train Latinas) had unintended consequences.

Black Favoritism

Latina staff protested that Latinas/os' interests and needs were not a priority for the clinic because the Black staff, as Tatiana (a Latina receptionist) claimed, "have the ear of the white administrators and managers." Latina staff complained that Black staff were their immediate supervisors and Latinas were at the bottom of the hierarchy at the clinic, allowing, as Amanda (a Latina client care coordinator) maintained, "the [white] bosses to make us bend over backwards so the Blacks feel okay at the clinic, like forc[ing] us not to speak Spanish."

A week earlier, the lead doctor, Dr. Koncord (a white woman) in a staff meeting had suggested that English be spoken all the time. Non-Spanish speaking staff (in particular Black, lower-level staff) had complained to Dr. Koncord that they felt disrespected, criticized, and made fun of because they did not know or were not willing to learn Spanish. Latina staff, including Amanda (the client care coordinator) and Tatiana (the receptionist), complained to me that they were now "prohibited to speak Spanish." To the Latinas, the one unique skill they possessed was being devalued.

Although Latinas and Black staff occupied roughly the same low-level positions, most Black staff had been working at the clinic for many years, and had seniority relative to Latina staff. The Latinas had been hired in the last few years, largely as a result of the high Latina/o immigration rate to North Carolina. Of the forty employees working at Care Inc. in 2002, 32.5% were white, 35% were Black, and 30% were Latinas. Again, this represented a fairly

dramatic demographic shift compared to the mid-1990s, when the majority of the staff was African American.

Latina staff told me that they suffered indignities at the hands of Black staff (but not the white staff). For Catalina, a Latina nutritionist, Latina workers were not a priority at the clinic. She said:

> Ellas requieren que las personas que hablan español, no hablen español en la clínica, incluso en sus horas del almuerzo. No sé que carajo están haciendo… ¿Aun en la hora del almuerzo? Porque…se sienten discriminadas, pero eso no es discriminación. Si tú prohíbes a una persona de habla hispana que hable español.. eso si es discriminación. En ninguna parte del mundo pueden prohibir que tú hables una lengua… ¿Qué pasa en la clínica para que se venga a poner ese asunto como un punto del orden del día?

> They require the people who speak Spanish not to speak Spanish at the clinic, even during their lunch break. I don't know what the hell they are doing…Even during lunch hour? Why… because they feel discriminated against, but that is not discrimination. If you prohibit someone who is Hispanic from speaking Spanish… that is discrimination. Nowhere in the world can they prohibit you from speaking a language… What is going on in the clinic so that they decide to make this a topic of discussion during the staff meeting?

Catalina tried to answer the question she had posed:

> ¿Sabes lo que me molesta? ¿Sabes lo que es? Es las prioridades que tienen. La prioridad es hacer todo para que no se molesten las personas que no hablan español, en especial los morenos. Eso me molesta.

> You know what bothers me? You know what it is? The priorities they have. The priority is to do everything so the people who do not speak Spanish, especially the Black people, do not feel bad. That bothers me. (Interview)

Other Latina staff echoed Catalina's discontent over what Dr. Koncord had said. Amanda, the Patient Care Coordinator, confided in me:

> No quieren que hablemos más en español, al menos que sea por trabajo… ¿Qué si fuera al revés, si fuera de la otra manera? Es la opinión de las morenas, y en particular la opinión de [la recepcionista], que: "todos los Hispanos tienen que aprender inglés." ¿Pero, por qué no debe ella aprender nuestro español? ¿Y si la incomoda tanto, y ella rechaza aprender

> They don't want us to speak Spanish, unless it is work related… What if the shoe was on the other foot, if it was the other way around? It is the morenas [Black women], in particular [the receptionist], their opinion that "all the Hispanics have to learn English." But, why shouldn't she learn our Spanish? And if it bothers her so much, and she refuses to learn Spanish,

español, por qué está ella trabajando aquí? Su trabajo es el servir a todos los pacientes, y aquí los pacientes son Hispánicos y Americanos. Y sucede que ahora, aquí, la mayoría de los pacientes son hispanos... y si tú lo piensas, son cinco morenas, en particular, que no hablan español.

why is she working here? Her job is to deal with all the clients, and here it is Hispanic and American clients. And it so happens that the majority of the clients now are Hispanic…And if you think about it, it is five *morenas* [Black women] in particular who do not speak Spanish.

When Latina staff complained to higher-level white staff, they were usually unable to effect change, and, according to the Latinas, white staff saw them as troublemakers.

The responsibility of the problem shifted from Dr. Koncord (who made the decision) to the Black women (who had filed the complaint). Blaming the Black women made sense in a context where Black women were seen as "pushy" and could force people (even whites) to accept their demands. This also reinforced the belief among the Latinas that the Black women on staff could not be true victims of racism because they could impose their will and receive preferential treatment from white administrators. When the Latina staff went to Dr. Koncord, they felt relatively powerless. For example, when Tatiana, the Latina receptionist, complained to Dr. Koncord about the Black receptionist's behavior, Tatiana said she received the cold shoulder:

Yo le dije a Dr. Koncord, "Ella es muy grosera con la gente latina." Le dije, "No sé si es grosera con todo el mundo. Pero yo la he visto ser grosera solo con los latinos."

I said to Dr Koncord, "She is very rude with Hispanic people." I said to her, "I do not know if she is rude with everyone. But I have seen her act rude only with Latinos."

Natalia: Y que paso?

Natalia: What happened?

Tatiana: Por un buen rato la doctora ni me hablaba. Solo nos decíamos "Good morning." Pero un mes después ella volvió a preguntarme como estaban las cosas, yo le dije, "*What do you need to know? Nothing has changed since I talked to you. What do you want to know?*" Yo estaba muy molesta, sabes.

Tatiana: For a good while the doctor did not talk to me. We would only greet one another, "Good morning." But a month later she asked me again how things were, and I said to her, "What do you need to know? Nothing has changed since I talked to you. What do you want to know?" I was very annoyed, you know.

After the staff meeting, one of the Latina medical assistants told me what she would have liked to have said in front of all the staff, but was afraid to:

> Sorry Dr. Koncord, but we know our rights and we know we got the right to talk Spanish, anything we wanted to talk that is not work-related. Nobody is going to take that away from us. No one. (Field notes)

Latina workers complained that the high-status white staff and administrators prioritized the Black staff's needs and wants. As a result, Latina staff claimed that their own needs were secondary to those of the Black staff. Dr. Koncord might have been trying to appease unhappy staff without realizing the history of racial tension amongst the low-status staff. The Latinas interpreted Dr. Koncord's actions as an example of Black women acting pushy and imposing their will on others (even whites). If Black women could force white administrators to change policies, the Latinas felt Blacks' claim of being victims of racism rang hollow.

CONSEQUENCES FOR REPRODUCING INEQUALITY

Dividing Low-status Workers

The strategies used by the Black and Latina staff to criticize and claim status over each other masked their own position as low-wage workers and cut off any possible avenues of solidarity among the low-status workers. They used racialized and gendered rhetorics to make sense of their feeling and justify their actions. The absence of readily available (and equally powerful) derogatory rhetorics regarding whites make criticizing white administrators more difficult. Without any alternative, positive rhetoric to help them

interpret their situation, they responded in three ways: sabotage, enforcing racial boundaries, and limiting access to health care to patients of the "other" race.

Sabotage

One potentialconsequence of competition among minority groups is sabotage. At the clinic, as I mentioned before, administrators asked Black staff to train Latina staff. If the Black staff sabotaged that training, the Latina's job might have been in jeopardy. The racist and sexist images of Latinas as "lazy" would become a self-fulfilling prophecy.

This happened to Gladyz. After working for six months at Care Inc., she had not been trained to do all the procedures required of a medical assistant. She was supposed to be trained by Desiree, the Black lead nurse, and Eva, a Black medical assistant. Gladyz explained:

Se puede decir que Desiree me entreno, pero falta mucho. Falta que me muestre como chequear la vista de los niños, como se saca sangre para chequear el azúcar y la hemoglobina, falta muchas cosas. Al menos me dejan hacer algo, y se pasa el tiempo. Pero todavía no hago todo. Y estoy en prueba! Eva y Genesis no me colaboran y si tengo dudas o una pregunta ellas se hacen de la vista gorda. Solo critican, se ponen bravas cuando me toca decirles que hagan algo porque yo no puedo, y dicen todo el tiempo que soy lenta. Además, me da pena, especialmente con las doctoras. Porque muchas veces, la mayoría de las veces, si me piden que haga algo, y no se hacerlo, o no me han entrenado para hacerlo, me toca decirles que Desiree no me ha entrenado. No quiero que piensen que es culpa mía o que soy perezosa. No es mi culpa. ¿Yo quiero aprender, pero si no me dicen como

Well, I guess you can say Desiree has trained me, but there is a lot that is missing. She still has to show me how to check the children's vision, how to take blood to check the sugar level or the hemoglobin, many things are missing. But at least they let me do something, and time goes by. But I still do not do everything. And I am on probation! Eva and Genesis (the other Black medical assistants) do not collaborate, and if I have any doubts or questions they ignore me. They only criticize, get mad when I ask them to do something when I can't, and they constantly tell me I am slow. Also, I feel ashamed, especially with the doctors. Because many times, most of the time, they ask me to do something and I have to tell them that Desiree has not trained me. I do not want them to think it is my fault or I am lazy. It is not my fault. I want to learn, but if they do not tell me how to do it, how can

hacerlo, como puedo hacerlo?

I do it?

The lack of training was taking a toll on Gladyz. She was worried she would get fired. This was not the only way Gladyz's effectiveness at work was being limited by Black staff. Because Eva "trained" Gladyz, she was also asked to monitor and evaluate her performance. If Eva's assessment of Gladyz's work was negative, this could have serious consequences: termination or no more overtime. This is what happened to Gladyz. As she recalled in an interview:

Yo estaba haciendo el *overtime*, el sábado. Me llamaron para decirme que no me iba a dar el *overtime* porque yo no calificaba. Me dijeron que una trabajadora de aquí, no la supervisora, les dijo que todavía no había completado el *training.* Entonces le dije, "Mira, eso no es mi culpa. Yo tengo todo el interés de aprender. Y es más," le dije, "si tú quieres, como aquí los miércoles estamos tarde y tengo que quedarme aquí podemos terminar mi *training*. Nadie me hace el *training,* y eso le correspondía a Eva y a Desiree. Y va Eva a decirles que no estoy calificada!" Y no puedo decirle nada a Desiree, la supervisora, porque son tan amigas. Ella no hace nada!

I was doing overtime, on Saturdays. They called me to say that they were not going to give me more overtime because I do not qualify. They said to me that a co-worker, from here, not a supervisor, had called to say that I had not completed my training. Then I said to them, "Look, that is not my fault. I want to learn. And even more," I said to them, "If you want, as we are here late on Wednesdays and I have to stay here, you can finish my training. Nobody has trained me, and that was Eva and Desiree's responsibility." And Eva goes and tells them that I am not qualified!" And I can not tell anything to Desiree, the supervisor, because they are such good friends. She does nothing!

Other staff at the clinic also commented that Eva "had it in for Gladyz." For example, Angela, the light-skinned Black laboratory technician[15], said to me in an interview:

> I know that Eva does not like Gladyz. I have heard how she talks about her, tells her she's too slow, tells her in a rude way she was doing something wrong, or… Even if Gladyz was doing it right, she would have something to say about it. Eva is always watching what time she comes in, what time she leaves. Being very judgmental. If you don't like somebody you'll come up with something, you'll make them look bad or, "She's not doing that right… she's too slow."

[15] Angela is an exception, and I will discuss her position below.

The organizational arrangements among low-status workers, such as training each other, turned into racial conflict and hostility. When those wielding racialized and gendered rhetorics have the power to evaluate, those rhetorics can be made to come true.

Enforcing racial boundaries

Another consequence of competition among minority groups is the constant differentiation, in negative ways, between Blacks and Latinas/os. Racist stereotypes for Blacks and Latinas/os rely upon racial solidarity and fixed racial boundaries. People who can switch from race to race call the concept of race (and their supposed corresponding personality traits) into question. People of the same race need to look alike (and if they do not look alike, they need to act alike) or else stereotypes (and their controlling power) are not as effective. To maintain their group image as "good workers" (and Latinas as "lazy") the Black staff distanced themselves from the Latinas. Correspondingly, Latinas saw themselves as kind and generous, unlike the "pushy" Black staff.

Consider the example of the one staff member whose racial identity was in question. Angela was a light-skinned Black lab technician who many clients assumed was Latina. Desiree (the Black lead nurse), Eva (a Black medical assistant), and Genesis (a Black medical assistant) did not get along with Angela. Because of Angela's light skin, Eva often asked her: "What are you? Why do you look the way you do? Are you really Black? I cannot tell you from Bibiana. You look Hispanic!" Angela said that some Black staff thought she was trying to pass for Latina. In an interview, Angela said:

> I was holding a Hispanic baby, the mother was having a procedure done, and Eva comes up and starts picking at the baby, you know, kind of playing with it or something. And Desiree walks up and the baby starts crying, and she said, "Oh, the baby wasn't crying with you, it must think you're Hispanic too—

> doesn't like Black people." I'm thinking, it's a little bitty baby, the baby doesn't know…

The dislike that Desiree, Eva, and Genesis had for Angela became evident in how they treated her when she became sick. Angela was in her early thirties and had had a partial hysterectomy when she was twenty-two. Four years later she had a complete hysterectomy. In June 2003, Angela started bleeding, and had surgery in September 2003 because she had "a third ovary and it had popped through the vagina and attached to the intestines and bladder" (Fieldnotes). Angela bled heavily, urinated on herself and was in a lot of pain. Angela reported that Desiree, Eva, and Genesis did not believe that she was sick or in pain, even when she told them, repeatedly, how she felt. Angela said to me:

> Desiree and Eva were not helpful. They thought I was playing, or not as sick as I was. They thought I was making it all up. They never knew how much I was suffering. They even made fun of the way I was walking. But I was in such pain. I could not stand up straight, and many days I could not even walk. Eva would shout, "Straighten up, Straighten up"…And I technically only took four weeks off. Desiree called me at home every day after the surgery and asked me: "When are you coming back, when are you coming back?" When I did not answer the phone because I did not want to be bothered, she would leave a message that went like this: "You must be out, which means you must be better. So come back." (Fieldnotes)

Angela confided in Bibiana and Gladyz (both Latina staff) and me about how sick she felt and the hostility she experienced from her Black co-workers. The reactions of Desiree, Eva, and Genesis make sense within in a context where racial groups are expected to stick together and act alike. Deviating from racial norms calls the authenticity of those norms into question. The Black women on staff garnered much of their status from seniority and their strength in numbers. Their seniority was difficult to challenge; but if Angela did not identify with the Black staff, their collective influence suffered.

Angela was aware of how the Black staff was struggling to maintain racial boundaries within the clinic. She feared she was seen as betraying her race by siding with the Latina staff. She said to me during a break:

> Eva doesn't want to learn Spanish and doesn't want to help me when I am doing labs to a Hispanic client. I can ask Bibiana and Gladyz for a word and they will write it down, or something. But I have to ask Bibiana and Gladyz to write it down when Eva is not around. She gets very upset when we all get together for lunch or they help me out. I am trying my best to learn Spanish. But if you don't speak good English, then Eva is, "She doesn't speak good English, she needs to speak better English." That bothers me, 'cause that's your language, I feel, well, speak it. 'Cause we're speaking our language, might as well speak yours. That bothers me. I don't expect Bibiana to speak without an accent, and I understand her fine, but some people say, "Oh, I don't understand her." Well, take your time and listen to her. People are impatient; that's what I think….

Maybe because she was marginalized by the Black staff in the clinic, Angela was the only Black staff member who viewed her own racial group as contributing to the racial tensions at Care Inc. She said:

> I think because there's more Hispanic workers who are speaking to the Hispanic community that's coming in, and the Americans that are there, have been there, I guess, from the beginning, and they're really set on not changing. The white people that are there are the doctors, and only one [white] doctor doesn't speak fluent Spanish, I think she should only see American-speaking clients, because she's pulling the nursing staff away to translate for her. And then you have the Black staff. Desiree, she speaks basic stuff, like me I guess, basic. Which is okay, because she gets the point across and she can understand. Eva speaks not a word, Margaret doesn't speak a word, and that's kind of… I guess they're afraid they'll lose their job, but…they don't like change. That's the only thing I can think of, it's a big change issue, and a job security issue. If you're going to hire Hispanic people you…have to realize if they don't speak English…that…you're going to have to give them time, because you're not even speaking Spanish. I don't speak Spanish properly, very well, broken Spanish, probably even wrong. At least I'm trying, they're not even putting forth the effort.

Angela understood why Blacks resented Latinas/os. She recognized that Black staff members were unhappy about the increase in the Latina/o population in North Carolina, and

the changes it forced upon the clinic and the demands it created on the workers. Angela also recognized that Black staff feared losing their jobs.

Black staff feared that Latinas/os would surpass them in the racial hierarchy, even though they (Blacks) are citizens, have been here much longer (and thus have been oppressed in the U.S. for longer), know the language, etc. Black staff's negative reaction to Angela demonstrated this: she was light-skinned and often taken for a Latina. For some Black staff, Angela may have represented a threat from Latinas/os, even though she was a light-skinned Black woman. Just as Angela could pass as Latina, this might imply that light-skinned Latinas could pass as white (which could potentially be even more threatening to the low-status Black women on staff). Latinas/os may pass as well, especially those who are lighter-skinned.

<u>Limiting Access to Patients of the Other Race</u>

Black and Latina staff acted upon racial tensions within the clinic by limiting access to health care to patients of the other race. Most of the Black staff maintained that Black people's interests and needs were no longer a priority at Care Inc. Stephanie, the Black triage nurse, often mentioned that "other Blacks" in the community asserted that the "clinic is catering to Latinas/os," and "they [Latinas/os] are why all the Black clients have left or were driven away."

For Margaret, the Black receptionist, the problem was that the clinic had disproportionately hired Hispanic health care workers to accommodate the increase in Hispanic clients. She said in an interview:

> You know, I think people should have a doctor or a nurse or a health care provider who they feel comfortable with. For many, and for me, that is a

> person that speaks English, and might look like me. And many feel that now [the] staff is Hispanic. They don't like that. They complain to me at the front desk. And I've even had some clients say if Dr. So-and-So wasn't such a good doctor, I would go elsewhere, but I've had her or him for years. To me it's a problem.

The racialized tensions among staff made it difficult for some Latinas/os to get adequate medical care at times at Care Inc. After she had seen a white mother and her six-year-old daughter, Stephanie (the Black triage nurse), commented to me:

> See, Natalia, this mom (a white mother of a six-year-old girl) did not embellish. She just stated the facts. This is why I let her see the doctor. Why do they, Mexicans, want their children to be sick? Why do they want the kids to be seen by the doctor? I feel sorry for the child (presumably referring to a Latina six-year-old we had seen earlier that morning), because the mom was coaxing her to say that she was sick. I asked her to say the truth…and I asked her if she could eat, drink, and she said yes. She said she did not feel sick. So, I did not let them see the doctor…the problem is the moms. Some get hostile if they can't get in. And it is a problem only with the Mexican community…I don't understand it, but there is something wrong with their idea of what it is to be a mom.

Prevailing rhetorics regarding Latinas/os and immigration described a battlefield of contested resources where Blacks were out to protect what was previously theirs and Latinas/os were seeking to exploit any available social service. For example, Stephanie felt obligated to protect the clinic from Latina/o clients who "work the system" and neurotically seek medical care for their children (to the point of coaxing their children to lie and pretend they are sick to ensure that they are seen by a clinician). Stephanie defined this as a problem of parenting skills. For example, after a Latina woman and her two sons left her office, she said to me:

> I can't let them see a doctor if they are not willing to tell me what is wrong with them. They don't want to see me, just the doctor, and I can understand that. But, they have to see me since it is my job to decide if they can get in or not. So like it or not, they have to deal with me. And the way to get to see a doctor is to be nice to me. If they do not want to talk to me, then it is likely they won't get through (Fieldnotes).

In this case, protecting a precious community service was easier for Stephanie since she interpreted her actions as defending the clinic from exploitive parents.

Latino fathers were not exempt from "bad" parent imagery. I was asked to translate for Antonio, a 33-year old Latino, who wanted to complain to the center manager about his visit with Stephanie. He began:

> Esta es la segunda vez que vengo a esta clínica. La primera vez vine a traer a mi hija, y hoy vine a traer a mi hijo. Cuando traje a mi hija, vine porque el colegio llamo y me dijo que la recogiera, pues ella necesitaba ver a un medico. Hoy, como esa vez, me pregunto la enfermera porque vine, que, que era lo que tenia mi hijo. No soy medico, ni enfermera, y por lo tanto no sé que es lo que tiene mi hijo. Sé que tiene temperatura, pero no sé cuanto. Después ella, en una forma muy despectiva me dijo que fuera al hospital, que no me podían ver. Siempre tengo problemas con ella, y no sé porque. Y siempre es con ella que tengo problemas. Doy gracias que aquí ella (mirándome a mí) y otras me trata como un igual y me hace sentir humano.

> This is the second time I have come to this clinic. The first time I brought my daughter, and today I brought my son. When I brought my daughter, I came because the school asked me to pick her up, because she needed to be seen by a doctor. Today, like the last time, the nurse asked me why I had come, and what my son had. I am not a doctor or a nurse, so I do not know what my son has. I know he has a fever, but I do not know how much. After that, she, in a very impolite way told me to go to the hospital, that they could not see us. I always have problems with her, and I do not know why. And it's only with her that I have problems. I give thanks that she (looking at me) and others treat me like an equal, and make me feel human.

Antonio was not the first Latino/a to complain about the treatment she or he received at the clinic. It was common for Latinas/os to complain to the Hispanic staff, in particular the two Latina MCCs, the Latina receptionist, and the Latina lab technician about the Black staff mistreating them. These complaints were then made known to the center manager and the rest of the staff, either in person or at staff meetings. Still, the mistreatment of Latinas/os by some of the staff—the same Black staff members—continued.

At the same time, Latina staff at Care Inc. also called upon racialized rhetorics of Blacks as rude and demanding in order make sense of their behavior at the clinic. When I asked

Tatiana, the Latina receptionist, "What has been your experience with Black clients at the clinic?" she replied:

Los morenos son demandantes. La gente blanca no lo es, la gente blanca es educada, la mayoría. Los morenos, ellos como que esperan mucho de uno, de ti. No te quieren dar la tarjeta. Por ejemplo, le digo, "*May I have your card, please?*" "*I don't have it.*" Pero así bien déspotas. Le digo, "*Well, I need some information to file in the computer. It's going to take me longer than what you think if you don't help me.*" Entonces me dice, "*What do you want me to do? I've been here a hundred times.*" Le digo, *"Well, I don't know you by name. I've seen you before, but I don't know you by name. What's your date of birth?"* Yo le hablo como ellos me hablan. Entonces se me hacen más demandantes los morenos. Aún más groseros.

Black people are demanding. White people are not. White people are educated, the majority. Black people, they expect a lot of me, of us. They do not want to give you their identification card. For example, I say to them, "May I have your card, please?" "I don't have it." They say it in a very arrogant manner. I say to them, "Well, I need some information to file in the computer. It's going to take me longer than what you think if you don't help me." Then they say to me, "What do you want me to do? I've been here a hundred times." I say to them, "Well, I don't know you by name. I've seen you before, but I don't know you by name. What's your date of birth? " I speak to them as they speak to me…So I think that Black people are more demanding. Even more rude.

Natalia:¿Y los blancos no son así?

Natalia: And the white people are not like this?

Tatiana: No. La gente blanca es más conciente. Más educada. Te dicen "*Thank you,*" te dicen "por favor." Los morenos muy poco saben decir "gracias" y "por favor." Muy poco.

Tatiana: No. White people are more gracious. More educated. They say "Thank you," they say "please." Black people don't say "thanks" or "please." Very little.

Blacks and Latinas identified problems at Care Inc. as a result of personality flaws associated with racial groups. These shared understandings made it easier for Blacks and Latinas to set aside resources for their own group. As a result, opportunities for solidarity among all poor North Carolinians (based on their shared interest as subordinates struggling together for limited services) were lost.

DISCUSSION

Gender, class, race, and ethnicity converged and gave meaning to the language Black staff used to label Latina staff as lazy and incompetent and Latina clients as bad mothers who used the clinic more than they should have. These racial and gendered reifications lead workers to exaggerate group differences and individualize structural problems, thus failing to recognize their shared interests.

Black staff women claimed that Latinas needed to do a better job of controlling their children. Black staff also maintained that Latinas abused the U.S. health care system by going to the clinic for trivial matters. And they asserted that Latinas made up symptoms or had their children do so to be seen by a health provider. Women are the ones held responsible for their children's health, and in the case of Latinas at Care Inc., they were criticized by Black staff for seeking medical care for their children.

It is culturally expected that mothers are responsible for raising children and that they must do it all with unconditional love (Johnson 1997:187). In our society, this sets the standard for the "good mother." This same gender ideology equates "good woman" with "mother" (Park 2002), so, it is the mother, not the father, who is expected to change the children's diapers, wipe their noses, quiet them and put them to bed. All these are expected of her, and her alone, regardless of how many hours she works outside the home, how little she is paid for this labor, and other circumstances she has to overcome on a daily basis (Hochschild 2003 [1989]). Women who ask for help, or are seen as not raising their children "properly," are often chastised for being bad mothers and not being able to cope with it all (Hays 1998).

Black women have provided the bulk of mental, physical, and financial support for their families. In Black communities, Black mothers are viewed as powerful people in a position

to serve as role models for the next generation (Collins 1999). However, this role comes at a cost for Black women, who often sacrifice their own needs while juggling work, family, and other responsibilities (while being rewarded with accusations of being bossy and demanding). By placing the sole responsibility and guilt on women, men are not held accountable; instead of mutual parenting, reproduction and parenting are duties that fall squarely on women.

Discrimination among minority groups (in this case, between Blacks and Latinas) produces and perpetuates inequalities. Prejudices and discrimination make it more likely for Black staff to enforce racial boundaries. They define one group—Blacks—as different from and better than Latinas/os, because the latter group presumably behaves in inappropriate ways. They also put up a wall, or a boundary, that emphasizes the differences (real or imagined) between racial and ethnic groups. Similarly, the prejudices Latina staff and Latinas/os clients have of Black people make it more likely for them to take racist imagery created by white elites and use it against Blacks all over again.

At Care Inc. this differentiation between Black and Latinas was a product of the process Schwalbe et al. (2000) defined as *defensive othering*, by which one group constructs boundaries between themselves and other marginalized groups, while at the same time defining themselves as morally superior to these (marginalized) out-groups.

They constructed these boundaries with recycled racialized and gendered rhetorics. This legitimated these stereotypical images and lent credibility to their accuracy because now they were finally being used by the same subordinate groups who had once protested their use upon themselves. Instead of casting aside these dangerous rhetorical weapons, they picked them up once again to defend their group interests.

Given their relative powerlessness, the Black staff's "difficult" attitude might have been a response to racism, sexism and class inequalities. Giving Latina staff "a piece of her mind" or "telling them off" might have been a way for these Black women to assert a sense of control, dignity, and self-respect in the face of systematic inequality and white racism outside the clinic and threats in the immediate work environment.

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CHAPTER 2

HELPING "THE NEEDIEST OF THE NEEDY": MORAL IDENTITY AND MATERNITY CARE WORK AT A COMMUNITY CLINIC

Meaningful work can aid in the safeguarding of a positive identity. Analyzing how workers maintain value in their work falls in the tradition of the work of Everett C. Hughes (1971) and the Chicago School of sociology. For example Joffe (1978) found that abortion counselors at Urban clinic, a private nonprofit family planning agency, wanted their clients to see and acknowledge abortion as morally problematic, something that clients were less and less willing to do. Clients' behavior was important to counselors because they felt ambivalent about abortion: they were pro-choice, but their involvement in the abortion process became troubling to them. Joffe found that clients' attitudes, in large part, determined whether counselors experienced their work as "heroic" or "suspect." Counselors were more likely to see their work as suspect when counseling cynical or detached women, clients who were hostile, and women who acted bored when discussing future contraceptive plans.

In her later work, *The Regulation of Sexuality: Experiences of Family Planning Workers* (1986), Joffe analyzed how birth control and abortion counselors at a clinic responded to difficult working conditions. The administrators of the clinic saw counseling as time-consuming, expensive, and a potential "Pandora's box" because the clinic would have to provide for all clients' needs. Counselors used coping strategies to deal with their high-intensity and low-paying jobs, including being pro-natalist. To avoid presenting an anti-natalist image of abortion clinic employees, pregnant staff received special attention.

Others corroborate how difficult it is for abortion providers to feel good about their work. In her ethnography of "Womancare," Wendy Simonds (1996) found that workers had difficulty assisting in second-trimester abortions. These health care workers questioned why women would wait so long. Yet these providers' strong belief in a woman's right to choose to have an abortion (even a late one) helped them come to terms with their work.

Even in "moral" work, such as volunteering at a homeless shelter, certain conditions can threaten volunteers' positive sense of self. Daphne Holden (1997) found that one shelter's hierarchy and job requirements diminished the volunteers' sense of moral integrity. Managers instructed volunteers to "spy on," "tell on," and "order around" guests in the shelters. According to Holden (1997), "the more rigorously the volunteers acted in their capacity as rule enforcers and shelter functionaries, the more likely it was that the guests would show hostility toward them" (125). Volunteers fashioned an identity as "egalitarian" by acting as friends to guests and enforcing rules at their discretion. Their success at feeling egalitarian depended on their ability to pretend that they were unaware of the status differences between themselves and their clients.

Relatedly, Stein (1989) found that volunteers in soup kitchens and food pantries expected their clients to express at least benign neutrality, and preferably thankfulness, toward them. Clients' expression of gratitude confirmed the volunteers' generosity and their self-concept as caring people. Clients' expressions of anger, hostility, arrogance, defiance, or resentment challenged volunteers' belief that they were doing good work.

The Maternity Care Coordinators (MCCs) in a community clinic I studied for 18 months also dealt with difficult working conditions. They were health care workers in charge of the perinatal program at Care Inc. They were poorly paid, overworked, and interacted with

clients experiencing physical and economic hardships. Despite these challenges, they constructed a positive self-image, a "moral identity" (Kleinman 1996:5) that helped them persevere under difficult circumstances. These MCCs saw themselves as good people in part because they were health practitioners responsible for helping the "neediest of the needy" (as one MCC put it).

Kleinman (1996:5) defines moral identity as:

> An identity that people invest with moral significance; our belief in ourselves as good people depends on whether we think our actions and reactions are consistent with that identity. By this definition, any identity that testifies to a person's good character can be a moral identity, such as mother, Christian, breadwinner, or feminist.

The MCCs' moral identity was a group effort, not solely the work of separate individuals. They collectively interpreted their difficult conditions at work as evidence that they were "heroic" workers (Joffe 1978). This identity, however, did have unintended consequences; namely, it allowed them to prefer some clients over others and still feel good about themselves and their work.

The clientele of Care Inc. was changing rapidly. The demographics of the local community and client populations had shifted dramatically from nearly all Black to nearly all Latina/o. Of the women the MCCs reported seeing in 2002, 86% were Latinas, 9% were Black, and 4% were white. According to the MCCs, most of these Latinas were thought to be recently arrived, undocumented immigrants (95% were poor or lower-class while the rest were lower-middle-class women who had no medical insurance). The MCCs identified Latinas as those who needed them the most, and became allies for them. In doing so, they lumped all the other clients—Black and white women—into the category they called "American." The term "American" became a synonym for privilege, at least relative to

Latinas. The white and Latina MCC's felt they needed to protect and save Latina clients from the discrimination they experienced in the wider society and, as the MCC's saw it, from the Black staff of Care Inc. as well.

It is not surprising for U.S. citizens to refer to themselves as "Americans." In the broadest use, the term includes any U.S. citizen, regardless of her or his ethnicity, race, sex, class, or sexual orientation. So how was it used by the MCCs? They used the term descriptively, but also at times in a way that was synonymous with privilege. For example, Melanie, a white MCC, used it in an interview to describe her family: "My dad is American. My dad is as white as white as you can be – born and raised in southern California. My mother was born in the Philippines…Her mother was half Spanish and half American." Melanie used it to describe her "American" clients as compared to her "Latina" clients:

> I think with my Latina clients that I work with that they expect a more personal relationship….The first month I was working at the clinic every time I meet a new woman they always asked me: do you have children? Are you married? You know, do you have a boyfriend? Why don't you have a boyfriend? (Laughing) Where's your family? They want to develop this personal relationship…The sort of interaction that I have is different to the one I have with my American clients because they're more used to a professional relationship. There is this black line that you don't cross it when you're talking with any professional, you know, your maternity care coordinator or your physician or your social worker. With my Latina clients, it's just, it's just different. (Interview)

The MCCs, however, also used the term "Americans" at times to refer to the Black clients who made their work difficult. When I probed for what they meant by "Americans," the MCCs replied that they meant Black women. For example, when I asked Yolanda, a Latina MCC, about her clients, she said in an interview:

El racismo es horrible departe de los Americanos, de los negros. Es increíble! Ahora, como esto es una posición distinta,

Racism is horrible from Americans, from Blacks. It is incredible! Now, as this is a different position, because supposedly the

pues supuestamente las MCC las respetan más, yo lo siento menos. Pero eso no quiere decir que yo no me siento identificada con mis compañeras que son hispanas también. Lo siento como que me lo estuvieran haciendo a mí…	MCCs are more respected, I feel it less. But that does not mean that I do not identify with my fellow Hispanic staff members. I feel it as if they were doing it to me...

The other MCCs echoed Yolanda's assessment of Black patients. They commented about "difficult" people by referring to them as "American." When I asked them to clarify what they meant by "Americans" they explained that these clients were Black women. By using "American" instead of Black, they avoided a racial discussion and focused instead on the lack of privileges experienced by Latinas. It also allowed the white MCCs to build solidarity with their Latina counterparts without appearing racially insensitive to other Black staff at the clinic. All MCCs felt Latina clients were especially "needy" and deserving of special protection; guarding over them was a crucial component of their moral identity.

In this chapter, I will analyze the three major strategies devised by the MCCs to feel good about themselves as health providers: defending clients from (Black) staff, categorizing clients as either "Americans" or "Latinas," and defining maternal health as a feminist mission. Finally, I will argue that the MCCs' investment in their moral identity kept them from seeing that they interacted with Latina and Black women differently.

METHOD AND PERSPECTIVE

As a participant observer and a volunteer at Care Inc., I "floated" through four of the six units. I volunteered at the MCC unit for approximately five months. I am fluent in Spanish and English and I often translated as part of my volunteer work. I observed and worked with the staff at the front desk, the maternity care coordination program, the Women, Infant, and

Child Nutrition Program or WIC department[16], and the clinical unit. I worked as a receptionist and client care coordinator, registered clients, and searched for medical records. In the clinic, I translated for clients while I observed the medical assistants, nurses, and clinicians in action. The activities of a volunteer were well suited to the job of observer. Over time, my presence was expected. I listened to and participated in conversations with staff and clients, and watched their daily routines. In the year and a half I did fieldwork (May 2002 to December 2003), I visited the clinic three days a week for five to six hours a day.

I am a Latina, but I came to know all of the staff well. As I established trust, all ranks of staff came to feel comfortable talking to me about themselves, other staff, and clients (of all races/ethnicities)[17].

This study is grounded in the multicultural feminist (Tong 1998) and symbolic interactionist perspective in sociology (Blumer, 1969).[18] I also used the approach of grounded theory (Charmaz 2000). I studied how the staff interpreted, foresaw, and acted, as

[16] The Woman, Infant and Children (WIC) program provides supplemental food package –in the form of vouchers—to pregnant, post-partum (up to 6 months), and breastfeeding women (up to 1 year), and infants and children up to their fifth birthday. To receive benefits, they must meet financial eligibility (below poverty level) and be at medical/nutritional risk.

[17] I did not fit the stereotypes the Black staff had of Latinas. For the Black staff, Latina staff and clients were "lazy," "bad mothers," and overusers of the health care system (See Chapter 1). Though these stereotypes were not of their own making, Blacks drew on them to claim status over the new threatening group: Latinas/os. The Latina staff also gave me "extra points" for not being a snob and being a committed and hard-working volunteer, despite having achieved a higher class status than most Latinas (i.e., a Ph.D. student). Similarly, the white staff frequently praised me for being a committed and hard-working volunteer who would never say "no" when asked to do something or help someone, and who got along with everyone.

[18] My study is multicultural in that it acknowledges that women, depending on their race, ethnicity, class, sexual preference, age, religion, educational attainment, occupation, marital status, health status, etc. experience oppression differently. It is global in that it recognizes that women experience oppression differently depending on whether they are citizens of a First or Third World nation (Tong 1998: 212).

well as the consequences of their behavior (for themselves and their clients). In particular I focused on staff interactions with each other and with clients in order to see if they sustained or challenged inequality (Schwalbe et al. 2000). As a critical feminist (Frye 1983; Bartky 1990) I explore issues of power in contemporary racial/ethnic and gender hierarchies, with a commitment to challenging racist and sexist ideology. These theoretical and political commitments inform my methods and analysis.

After each day at Care Inc. I wrote detailed fieldnotes. I began analyzing the data by writing notes-on-notes (Kleinman and Copp 1993) and longer analytic memos (Lofland and Lofland 1995). Collecting and analyzing the data simultaneously allowed me to test my explanations and modify my interview guide. I interviewed 21 of the 40 employees, including those who worked at the front desk (center manager, reception, registration, client care coordination [or referrals], billing, and medical records), the clinical area (triage nurse, nurses station, laboratory, and clinicians), the Maternal Care Coordination program, and the WIC and Nutrition Department. I also collected documents produced or used by the health care providers, as well as flyers and brochures available to the clients. These provided additional sources of data about my setting.

SETTING: CARE INC.

Care Inc. is a partially federally funded, not-for-profit clinic that provides health care services and education to more than 5,500 clients a year (most of whom are Latinas/os). Patients are charged on a sliding scale. During my fieldwork, the clinic was open five days a week. The services offered included primary and preventive care for children, teens, adults and older people, physical exams, laboratory tests, and flu shots. The clinic also offered

nutritional services: WIC and “Nutritional and Dietary” counseling. Patients had access to a pharmacy and to dental services (terminated in October, 2002, but re-opened in December 2003), as well as women’s health services. These included: family planning, free pregnancy testing and counseling, childbirth classes, certification for Baby Love Program for Prenatal Care[19], and gynecology services (including pap smears). These services were provided by clinicians and the MCCs. This chapter focuses on the work done by the MCCs.

The MCCs provided family planning and contraceptive counseling for all women who came to Care Inc. for a free pregnancy test. They saw all new prenatal clients before their first visit with a clinician. In this one-hour visit the MCCs provided clients with information about Care Inc.’s services, the WIC and Nutrition program, and the state Baby Love Program. They also took applications for Pregnant Women’s Medicaid Program and Infants’ and Children’s Medicaid program[20]. In this first visit, and in subsequent prenatal visits, the MCCs evaluated the women’s pregnancy-related needs and recommended services or plans to meet those needs. The MCCs were also trained to intervene in cases where they suspected a woman was being abused by her partner or when a child was being mistreated or abused. The MCCs taught a 6-week birthing class for Latinas in their second or third trimester of

[19] The goal of the Baby Love Program, which began in 1987, is to reduce NC's high infant mortality rate by improving access to healthcare for low-income pregnant women and children. Women receive care from the beginning of pregnancy through the postpartum period. Nurses and MCCs help women obtain medical care and social services. In addition Maternal Outreach Workers–specially trained home visitors—work with at-risk families to encourage healthy behaviors, and ensure that they are linked with community resources. Other services include childbirth and parenting classes, in-home skilled nursing care for high-risk pregnancies, nutrition and psychosocial counseling and postpartum/newborn home visits. (http://www.dhhs.state.nc.us/dma/babylove.html)

[20] Medicaid is an assistance program that provides medical and health-related services for low-income families. Medicaid is a jointly funded cooperative venture—which began in 1965—between the Federal and State governments to assist States provide medical care to eligible needy persons. (See: http://cms.hhs.gov/medicaid/mover.asp)

pregnancy. This program was implemented in 1988 when Care Inc. became one of the 206 federally funded community centers to which the U.S. Congress gave money "to implement services to improve pregnancy outcomes and reduce infant death rates" (History and Introduction to Care Inc. Perinatal Program). When the clinic first opened in 1970, 80% of the clients were Black. By 2002, 57% of the clients were Latinas and Latinos, 17% were white, and 16% were Black. Only a year later the proportion of Latina and Latino clients had increased by 10%[21].

There were approximately forty employees at Care Inc. From the time I started my fieldwork, some workers were moved to other clinics (for example, the three staff who had worked at the dental office that was closed in October of 2002). Two staff members from other clinics came to work at Care Inc. Two others quit or were fired by the center manager, and five new staff members were hired. The high turnover was likely due to the stressful working conditions at the clinic.

Of the forty employees, 13 were white, 14 were Black, and 12 were Latinas. Ninety-five percent of the employees were women; only two men worked at the clinic during my fieldwork. One was a clinician; the other worked as the WIC administrator[22]. The

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[21] Since 1990 some southern states, including North Carolina, have become common destinations for Latina/o immigrants. According to the U.S. Census Bureau, North Carolina's Latina/o population grew 394 percent since 1990. According to census figures, Latinas/os account for 4.7 percent of the state's population. The rapid growth of the state's Latina/o population outpaced its growth nationwide, where the Latina/o population increased almost 60 percent. (Source U.S. Census Bureau. (http://quickfacts.census.gov/qfd/states/37000.html.)

[22] The executive director was a Black male. His corporate office was not on site. During the year and a half of fieldwork I saw Mr. Mackenzie twice. Once, when I asked him for permission to conduct fieldwork, and the second time was at the diversity training session (See Chapter 2). Mr. Mackenzie's office was miles away from the clinic. The staff rarely saw him.

employees' ages ranged from the mid-twenties to over sixty. Most employees were in their thirties, forties, and fifties. The 40 employees worked in one of 6 different "areas": (1) the front desk (center manager, reception, registration, client care coordination [or referrals], billing, and medical records), (2) clinical areas (triage nurse, nurses station, laboratory, and clinicians), (3) WIC and Nutrition Department, (4) pharmacy, (5) MCC program, (6) and dental clinic (while it was in service).

Although the racial composition of the staff was numerically balanced, the most powerful positions were held by whites: they were the clinicians, the unit directors, and the center manager. The Black staff occupied low-status positions (receptionist, medical assistant, laboratory technician, WIC/Nutrition Department coordinator, and nutritionist). There were exceptions, however. There was a Black female doctor at the clinic (who left to work in private practice in December 2003) and the Black lead nurse, and, as pointed out earlier, the executive director was Black. Latinas also occupied low-status positions (receptionist, client care coordinator, medical assistant, laboratory technician, WIC administrative assistant, and Pharmacy assistant). The MCCs held a mid level position.

My observations and analysis center on three of the clinic's four MCCs. Rachel, the supervisor of the MCCs and an MCC herself, was white, a U.S. citizen, and the only MCC not fluent in Spanish. She interacted only with English-speaking clients (white, Black or Latina). She had worked at Care Inc. for over four years and oversaw the work done by the other three MCCs. Because Rachel spent most of her time writing grants and doing

administrative work during my time at Care Inc., I rarely observed her interacting with other MCCs or clients[23].

Melanie, the youngest MCC, was a 25 year-old white U.S. citizen. She started working at Care Inc. in 2001 after receiving a Master's degree in public health. Melanie left Care Inc. in December 2002 to study medicine at a university on the west coast. She was replaced four months later by another young white U.S. citizen who worked for only a few months before quitting. When I finished my observations, she had not been replaced. Yolanda, a Latina in her late-thirties, came to the U.S. seven years earlier from her native country, Venezuela. Yolanda had been working at Care Inc. for over five years, the longest of the three MCCs. Yolanda quit her job and left for a higher paying one in March 2003. MariaTe, also Latina, was in her early thirties and came from Mexico in 2000. Both Yolanda and MariaTe had U.S. green cards. Although MariaTe's official job title was that of an MCC Assistant she did almost the same work as the other MCCs[24].

THREATS TO MCCS' MORAL IDENTITY

The MCCs came to Care Inc. with a strong commitment to being health care providers who worked with Latinas. For example, when I asked MariaTe, in an interview, how she

[23] The MCCs did recognize the demands put on Rachel in her supervisory position. For example, Melanie, when complaining about a client she had just counseled, said: "Rachel usually sees the American women. But like she is not here, we have to do it. I don't know what is going on with her. She is always writing her grants, and now that Yolanda is not here, I was hoping she would chip in. But nothing!" (Field notes). Similarly, when MariaTe and Melanie were complaining about Rachel, they said: "If she only opened her door, she would know what we do!...Or if she were here" (Field notes). They made similar complaints to me on other occasions.

[24] Melanie often pointed this out: "MariaTe does the same work I do, without the respect, the salary, or the title we have. I wish she could apply for my job, but this is a sore subject…" (Fieldnotes).

came to work as an MCC she replied: “En México, enseñaba ética. Creí que seria una experiencia positiva el trabajar con mujeres Hispanas que estaban embarazadas. Era muy importante para mí el tener contacto con hispanos, en mi idioma, español.” [In Mexico, I used to teach ethics. I thought it would be a great experience to work with Hispanic women who are pregnant. It was very important for me to have contact with Hispanics, in my own language, Spanish.]

Similarly, in an interview, Melanie stressed the importance of doing reproductive health with Latinas:

> I knew that I wanted to find a job and stay in the area, and I wanted to find a job in the area of reproductive health and also working with the Latina community. That’s how I ended up doing maternity care coordination.

Melanie saw her job as empowering and educational, and herself as a big sister to the women:

> [To be an MCC] is a combination of social work, health education, and care coordination for pregnant women—from the time the women find out they are pregnant until after they have their babies…I also do a lot of reproductive health counseling, including pregnancy counseling and birth control counseling, and I also teach childbirth classes…I work with Latinas, who are very socially isolated. They don’t know anybody. A lot of times they’re not quite sure how to navigate the system yet. They don’t really know how to—which people who speak English take for granted—take care of the bills at [the hospital]. And I think that pregnancy is a time in anyone’s life where you need extra support…So I feel that my role is that of a social worker. In a lot of ways it’s being a big sister. I am that someone they can come in and talk to, bounce ideas off of and get reassurance from and get support from.

Melanie’s comments foreshadow how the MCCs devised strategies to feel good about themselves as health providers by constructing maternal care as a feminist mission to help those they saw as the “neediest”: Latinas.

The challenging working conditions at Care Inc. were important to their moral identity. They were poorly paid. It was not uncommon to find them glancing at their checking

account balance, listing the bills they had to pay, and deciding which ones would get paid and which ones would have to wait until the next check. I often observed one MCC asking another (or me) if they could borrow fifty to one hundred dollars to buy groceries or pay for medicine for a sick child. Without monetary compensation, they sought other avenues of value from their work.

The MCCs felt that their work presented a series of difficulties besides low pay. They also worked at an overwhelming pace with too many tasks to complete in a day's work. Rachel said:

> We try to provide the best service and care we can to those we can serve. Unfortunately we cannot care for everyone. Not to all that we should. All, [that] would be the goal, but it is not realistic. We are overworked as it is. Supposedly a full-time MCC should see 100 women a year, if they are American, and only 70 if they are Hispanic. And last year, the 3 MCCs saw 600 women, and more than 90% of those were Hispanic. We served more than twice the women we should. (Fieldnotes)

The MCCs constantly noted the number of clients they saw. I often overheard the MCCs protesting: "The caseload that we have is ridiculous. I mean, we each have, right now, probably 120 cases open… and 50 cases are considered full-time." The MCCs recognized that their clients suffered as a result of their case load. As Melanie said in an interview:

> My biggest fear is that one of my clients will fall through the cracks 'cause I have so many clients and I try to keep up with all of them, but it's hard. Sometimes I worry that something horrible has happened to one of my clients, you know? That she's in a really bad case of domestic violence or that there's something wrong with the baby or she's not coming in for her prenatal care and that she's fallen through the cracks.
>
> Natalia: What do you mean by the term "falling through the cracks?"
>
> Melanie: That I wouldn't catch it. That I wouldn't, that I have so many clients that I wouldn't follow up with her, that I wouldn't contact her and see what was going on, you know? That I wouldn't know that something like that was happening. And I'm sure it does happen. That is my biggest fear.

MariaTe also said she had no time to call her clients. She said to me at the clinic:

Tengo más de 100 pacientes y siempre estoy tan ocupada hablando con una o la otra, haciendo citas prenatales, haciendo citas en el hospital, y llenando todo el papeleo. ¿Como quieren que haga yo, como me corresponde, mi trabajo? Debería llamar o ver cada una de mis pacientes al menos una vez al mes, ¿pero como? Según las reglas o descripción de mi trabajo eso es lo que debo hacer. Nunca lo hago. No hago mi trabajo, ¿con que tiempo?

I have more than 100 clients and I am always so busy talking with one or another, doing prenatal visits, scheduling appointments in the hospital, and filling out all the paperwork. How can they expect me to do my job as I am supposed to? I should call or see each of my clients at least once a month, but how? According to the rules or my job description that is what I must do. I never do it. I don't do my job, with what time?

The MCCs also sacrificed prestige within the local community because most of their clients were poor (often undocumented) Latinas. The clients' race, ethnicity, and class can, as Goffman put it, "spoil" the MCC's identity (Goffman 1961). This is particularly true in North Carolina, where many citizens and members of the legislature see poor Latinas as low-status immigrants, undeserving of services. The MCCs often talked about uncooperative legislators who gave the clinic's clients low priority. In a staff meeting, Rachel, the supervisor of the MCCs, complained:

> We can only put out fires, there is no preventive care. We do not have the time or staff. The problem is of course that I cannot convince the legislature to give us money and the resources we need. They don't care about the population we serve. They are full of bigotry. They don't care about Hispanics because they cannot vote. Thus, there are no grants, no support, and no money. (Fieldnotes)

All the MCCs claimed that many U.S. citizens disliked Latinas/os, defining them as threats to U.S. values. For example, the MCCs often cited the visit by David Duke, head of the National Organization for European American Rights, who came to Siler City, North Carolina, and denounced Mexicans, immigrants, and other minorities as threats to national unity (Anti-Defamation League 2006). The MCCs took these limited resources and unpopular clientele as a challenge and a call to action.

The MCCs believed that negative feelings about Latinas/os were also shared by some Black North Carolinians. A major oral history initiative (Hemming et al. 2001: 29-30) documented racial tensions and struggles among "old-timers" and their "new" neighbors in various communities in North Carolina. As a Black resident explained: "You're talking about a whole different culture that you want me to trust myself with. No, no, no, no. That's taking me out of my comfort zone first of all, and then you are asking me to do something I don't understand because I don't speak Spanish." The white and Latina MCCs saw their work as standing up for a Latina/o community that was under attack on multiple fronts.

Even within the agency, the MCCs felt that other staff saw their work as less valuable. A few months after Melanie left, Yolanda said to me and MariaTe:

Antes nosotras [las MCCs] teníamos mas prestigio, pues había americanas que eran MCCs y teníamos más pacientes americanas. Como ahora somos todas Hispanas, con la excepción de Rachel y ella nunca esta aquí, y la gran mayoría de nuestras pacientes son Hispanas, ¿que prestigio o respeto nos van a tener?	In the past we [the MCCs] had more prestige, because an American was an MCC, and more of our clients were American. Since we are all Hispanic, with the exception of Rachel, and she is never here, and the majority of our clients are Hispanic, what respect or prestige are we going to have?

Without prestige, the MCCs turned to each other for support. This solidarity fostered their moral identity because they shared a sense of unity against all odds. As a group, the MCCs often collaborated on how to deal with work-related stress.

Racialized tensions among staff made the MCCs' work difficult, especially for the Latina MCCs, who often complained about the "bad environment" and the snide remarks they heard from Black clients and Black staff. This is illustrated by the following conversation between Yolanda and MariaTe:

Yolanda: Sabes MariaTe, cada vez esta mas pesado trabajar aquí por el mal ambiente que hacen algunos pacientes	Yolanda: You know, MariaTe, each time it gets more difficult to work here because of the bad environment created by some of the

Americanos y las morenas que trabajan aquí.	American clients and some of the Black staff women that work here.
MariaTe: ¿Que paso?	MariaTe: What happened?
Yolanda: Esta clínica ahora tiene mal ambiente. La triage nurse no me deja hablar y no me deja hacer mi trabajo. Me cayó. No me dejo contarle nada. Solo me dijo que si ella quería ver a alguien inmediatamente, si no podía esperar, que se fuera a emergencias….No quieren que uno haga su trabajo. ¿Para que, si la mayoría de nuestras pacientes son Hispanas? Nuestro trabajo no cuenta, porque nuestras pacientes no cuentan. Solo estamos aquí para molestar. Somos una imposición.	Yolanda: Right now this clinic has a bad environment. The triage nurse [a Black woman] doesn't let me talk or do my job. She did not let me talk. The only thing she told me was that if she wanted to see someone right away, if she could not wait, she should go to the ER…. They don't want us to do our job. What for, if most of our clients are Hispanic? Our work does not count because our clients do not count. We are only here to be a nuisance to them. We are an imposition.

The tensions were so high that administrators and doctors organized a cultural diversity session, led by a Latina and a Black woman (see Chapter 3). These Latina MCC's responded to these tensions by making their work "count" regardless of what others thought of them, or their Latina clientele. Their work became even more important to them because they believed if they did not do it, no one else would. The MCCs interpreted racial tension as harmful not only to them, but to their clients.

STRATEGIES FOR MANTAINING HEALTH PROVIDER AS A MORAL IDENTITY

The MCCs devised three strategies to maintain "health provider" as a moral identity: (1) defending clients against Black staff, (2) categorizing clients as either "Americans" or "Latinas," and (3) defining maternal health as a feminist mission.

Defending Latina Patients Against Black Staff

The MCCs maintained that they had to defend Latina clients against prejudiced Black staff at the clinic outside of the MCC unit. In addition, Latina staff complained about the "bad environment" and the negative remarks they heard from Black clients and Black staff about Latinas/os (both staff and clients). I observed Black staff complaining often about the Latina/o clients and Latina staff. For example, some Black staff told me in interviews that the source of the difficulties at work were Latina staff: "staff have not been able—or willing as some are saying—to get the job done"; staff "form racial cliques and are against the other people." The low-status workers, Blacks and Latinas, formed racially divided groups that prioritized their own racial group interests (see Chapter 1).

The Black staff members' attitude might well have been their response to the rapid change in clientele at Care Inc. In 1970, when the clinic opened, it served Black community members almost exclusively. However, in the past 5 to 10 years, it had come to serve Latinas/os almost entirely. Black staff might have felt that the clinic was replacing the needs of the surrounding Black community with the needs of Latinas. Although these demographic changes within the community were beyond the control of the staff at Care Inc., they affected the way the staff viewed their actions. Insensitive treatment could be interpreted as defending one's group interests. Privileging one group of clients over another could be seen as defending them against unjust attacks. All of these actions had to be negotiated within a moral identity that justified them as fair.

The MCCs complained about the malicious comments about Latina clients they heard from Black staff, and they claimed that they needed to protect Latina clients from them. For example, MariaTe acknowledged that she spent a lot of time "defending and protecting" Latinas/os. I recorded the following conversation between MariaTe and Melanie:

MariaTe: Es increíble, pero aproximadamente 50% de mi trabajo es defiendo a hispanos. Toca protegernos. Los negros defienden a los negros, y los hispanos defienden a los hispanos. Y te digo los negros protegen a los negros, entonces nosotros [hispanos] tenemos que unirnos en las broncas.

Melanie: Lo se. Yo me la paso también ayudando a mis hispanas.

MariaTe: It's incredible, but approximately 50% of my job is defending Hispanics. We have to protect ourselves.The Blacks defend Blacks, and Hispanics defend Hispanics. And I tell you that the Blacks protect Blacks, so we [Hispanics] have to unite ourselves in the fights.

Melanie: I know. I also spend my time helping my Hispanics.

The Latina MCCs saw themselves as more than just health practitioners; they were spokespeople assigned the duty of protecting the reputation of their community (and, by extension, themselves). By complaining to Melanie, MariaTe was also seeking solidarity between white and Latina staff. Latina clients also felt comfortable complaining to both white and Latina staff about the tone, comments, treatment and/or service they received from "las morenas" (Black female staff). Latina/o clients claimed that they were mistreated by the Black staff. When I asked the MCCs to describe some of the clients' complaints, they recalled: "Son tan bruscas [they are so rough]," "Me tratan peor que un animal, como si no fuera un humano [They treat me worse than an animal, as if I were not human]," and "No nos quieren aquí, y no les importa lo que nos pasa o le pasa a mis hijos [They do not want us here, and they do not care what happens to us or to my children]." These complaints were interpreted as proof by the MCCs that they needed to look out for each other and protect Latina clients if need be.

Latina and white MCCs said they frequently overheard Black staff and Black clients make snide remarks about Latinas. They complained to each other (and to me) about some of the following comments: "Another pregnant woman? They breed like bunnies!" or "The first thing they [Latinas] do when they get here is get pregnant. They do it for citizenship."

These comments gave the MCC's yet another reason to feel protective of the Latina clients. The racialized tensionsat the clinic reinforced the MCCs' focus on Latinas as the neediest and themselves as their protectors. MariaTe and Yolanda often commented on how they too had been victims of discrimination by Blacks:

MariaTe: Natalia, antes era difícil pedir una licencia de conducir. Ahora es imposible para hispanos. La primera vez que fui a sacarla no me pasaron. Me toco tomar el examen de nuevo porque cometí un error. ¡Solo uno! ¡Maneje perfecto por 15 minutos!	MariaTe: Natalia, before it was difficult to get a driver's license. Now it is impossible for Hispanics. The first time I went to get my driver's license I did not pass the driving exam. I had to take the exam again because I made one mistake. Only one! I drove perfectly for 15 minutes!
Yolanda: Para mí fue peor. Yo lo trate de sacar en Atlanta. La morena me pregunto, "¿Sabe inglés?" Le dije, "No mucho." Y me dijo, "Vuelva cuando sepa inglés." Se los juro, eso me dijo. Son la mierda.	Yolanda: My experience was worse. I tried to get a driver's license in Atlanta. A Black woman asked me "Do you know English?" I said, "Not much." And she said, "Come back when you know English." I swear, that is what she said. They are shit.

By othering the Black staff, the Latina MCCs defined Latinas as good or valued. This process of "defensive othering" (Schwalbe et al. 2000) is one in which one "othered" group—Latinas— constructs boundaries between themselves and other stigmatized groups (in this case, Black staff), while at the same time defining themselves as morally superior to them. The more difficult the MCCs' work, the greater sense of importance they attached to it.

Difficult "Americans" and Sweet Latinas

Although Black and white clients only occasionally behaved with an "attitude" toward the MCCs, these incidents made a strong impression on the three MCCs. In the five months I did fieldwork at the MCC unit, the three MCCs saw few Black and white women. A couple

of these Black clients at the clinic expressed anger, hostility, defiance or resentment toward the MCCs, especially the Latina MCCs. I recorded this interaction in my fieldnotes:

> A Black woman, in her mid- or late thirties was waiting to talk with Yolanda. Yolanda had her door closed as she was counseling a Latina. The Black woman paced outside Yolanda's door and said out loud: "This is ridiculous, I have been waiting here for more than thirty minutes. I have things to do. I can't be here all day like *others*." MariaTe, after counseling a Latina, asked the Black client: "Can I help you?" The woman replied: "What?" MariaTe repeated her question: "Yolanda is busy, can I help you? The woman said raising her voice and talking slowly: "I guess you will do."

This Black client complained that Latina clients "stayed all day long" at the clinic, a luxury she could not afford. It is true that many Latina clients preferred to do everything in a day. Latina clients told me that they would schedule most of their appointments on one day because childcare, transportation to and from the clinic, and taking a day off from work were costly and sometimes impossible.

After counseling this client, MariaTe said to me, "They talk to me as if I were a retard." During my observations of the MCCs, MariaTe asked me on five occasions to take a call from an "American" client she could not understand and who was "being rude." MariaTe and Yolanda often asked Melanie or Rachel to handle a client who was making them feel incompetent. The white MCCs came to the aid of the Latina MCCs, saying how "unfair" the client was, how "sorry" they were, and that they would "deal with the problem."

The Black clients' attitude might well have been a response to racism against Blacks outside the clinic. It might also have been a response to the rapid change in the demographics of the clients served by Care Inc. Black clients might have felt that the clinic was replacing their needs with the needs of Latinas. When a few Black clients gave the MCCs "a piece of their mind," "told them off," or demanded services, it might have been a way for these Black women to assert a sense of control, dignity, and self-respect in the face

of systematic inequality and discrimination. These interactions with Black clients also served a dual purpose for the MCCs: it made their work environment more challenging (and thus more important), as well as an opportunity to come to the protection of their Latina clients.

The MCCs reported that their difficult clients were Black women who they categorized as “Americans.” The MCCs complained about women who were not grateful for their help. Melanie, after giving the results of a pregnancy test to a Black client, said to MariaTe:

Fue muy descortés y demandante. Claro, tenia que ser Americana. Nueve de diez veces, el problema son las Americanas. En un año que trabajo aquí, lo juro, es la más descortés. Las hispanas son cariñosas, son mas como mis amigas.	She was rude and demanding. Of course she had to be an American. Nine out of ten times, the problem is the Americans. In the year I have been working here, I swear, she is the rudest. The Hispanics are caring, they are more like my friends. (Fieldnotes)

Melanie said to me“I work with an American population who tends to be problematic.” Melanie was put off by clients whom she saw as not having a legitimate need for their services.

For the Latina MCCs, the clients who made them feel incompetent were “Americans” whom they labeled “difficult.” After counseling a Black client, Yolanda said to MariaTe and to me:

Espero que contraten a otra MCC pronto. Saben, las Americanas me hablan con un tonito, es como diciéndome, “Si, tu eres una pendéja.” Y se ponen bravas cuando no les entiendo lo que dicen y les pido que repitan.	I hope they hire another MCC soon. You know, the Americans talk to me in a tone, as if they were telling me, “Yes, you are stupid.” And they get upset when I do not understand all that they say and I ask them to repeat it.

When I asked Yolanda, “What has been your experience with clients at the clinic?” she replied:

Las morenas son demandantes. La gente blanca no lo es. La gente blanca es educada, la mayoría. Las morenas esperan mucho de uno y además son groseras. Claro que no todas, pero si la mayoría de morenas.

Black women are demanding. White people are not. White people are educated, the majority. Black women expect a lot of me and are rude. Not all of course, but most of the Black women

Natalia: ¿Y las blancas no son así?

Natalia: And the white women are not like this?

Yolanda: No. La gente blanca es más educada. Las morenas nunca dicen “por favor” o “gracias.”

Yolanda: No. White women are more educated. Black women don’t say “please” or "thanks.”

The three MCCs asserted that they preferred Latina clients. Latinas’ gratitude to the MCCs made it easier for the MCCs to see themselves as good health care providers (and helping those truly in need). The interactions I observed between the MCCs and the Latinas were relaxed and informal. At an MCC staff meeting, Yolanda, Melanie, and MariaTe were talking about Doña Rosario, a 45-year-old woman, who had recently given birth:

Melanie: Acabo de ver a Doña Rosario. La bebe esta tan bonita. Y ella es tan dulce. Ella es una de mis pacientes favoritas.

Melanie: I just saw Doña Rosario. Her baby is so pretty. And she is so sweet. She is one of my favorite clients.

MariaTe: Ella es una de las mías también.

MariaTe: She is one of my favorites too.

Melanie: Ella tiene 45 años y acaba de tener una bebe. Fue un accidente de menopausia. Ella cuando supo [que estaba embarazada] no le dijo a nadie de su familia, por pena. Ella estaba apenada. Solo les dijo a los 6 meses. Pero la ayudan tanto. Siempre esta acompañada, y la quieren mucho. Ella tiene 4 hijos más.

Melanie: She is 45 years old and just had a baby. It was an accident of menopause. When she learned she was pregnant she did not tell her family because she was embarrassed. She only told them when she was six months pregnant. But they help her so much. She is always with a family member, and they love her a lot. She has 4 other children.

Yolanda: Si, es de Michoacán. Es tan dulce!

Yolanda: Yes, she is from Michoacán. She is so sweet!

MariaTe: Y la bebe es preciosa. Doña Rosario siempre me pregunta, “Como la vez, bonita hey?!”	MariaTe: And the baby is precious. Doña Rosario always asks, “What do you think of her? Pretty eh?

The MCCs could have seen this woman as an ideal client, a person under their care who had an unwanted pregnancy. Or, they might have seen this woman as having initiated prenatal care very late. Instead, Doña Rosario was their favorite. But consider how they reacted to a Black teen who came in for a pregnancy test, even though she was taking birth control pills and had used condoms during sex. Melanie brought up this patient as an example of someone who was “difficult”:

> I have this one woman, who, she comes in to do a pregnancy test every two weeks, and I just think she does it ‘cause she likes to touch base. I mean, she’s taking birth control pills and using condoms. I mean, there’s like no chance in the world that, that she is going to get pregnant, but, she just needs someone to touch base with. She came in when she got engaged and showed me her engagement ring and, that’s kind of all done on the guise of pregnancy testing. But, she pretty much knows she’s not pregnant.
>
> Natalia: Is she Latina?
>
> Melanie: Oh no, she is an African-American teenager. Americans are the difficult ones. (Fieldnotes)

Melanie might have seen this woman as an ideal client, a person under her care who was doing things right. Or, she might have seen this teenager as lonely and in need of care. Instead, she saw this client as wasting her time. Prioritizing Latina clients’ needs did not threaten Melanie’s moral identity; instead, it bolstered it (because Latina clients do not waste limited time and resources just to “touch base”).

The MCCs thought of Latinas as grateful and respectful. When Latina clients did not act this way, the MCCs described them as behaving “like Americans.” For example, MariaTe, Yolanda, and I had the following conversation after a childbirth class:

MariaTe: Mi problemas es con Andrea.	MariaTe: My problem is with Andrea [a patient].
Natalia: ¿Que problemas tienes con Andrea?	Natalia: What problems do you have with Andrea?
MariaTe: Ella es snob y racista. Ella y yo fuimos a una charla en la comunidad y lo único que Andrea hacia era hablar mal de las mujeres que estaban ahí. Decía, "Mira, acabadas de bajar del pueblo." Es racista y clasista. Y yo digo, no niegues la cruz de tu parroquia. La familia de ella vino aquí como inmigrantes, sin papeles y ella nació aquí. No niego que los papas trabajaron mucho y volvieron a Colombia con plata… pero todavía.	MariaTe: She is a snob and a racist. She and I went to a talk in the community and the only thing she would do is to talk bad about the women who were there. She said, "Look, they act like they just arrived from a small town." She is a racist and a classist. And I say, don't forget where you came from. Her family came here as immigrants, without papers, and she was born here. I know her parents worked hard and went back to Colombia with money, but anyhow.
Yolanda: Si, ahora en clase era agresiva, impaciente. Ella tiene todo lo que se necesita para ser prepotente en este país. Ella es Latina, pero actúa como Americana. De eso no nos deja la menor duda: Le deja a todos saber que es nacida aquí, que su novio es gringo, que sabe el idioma, y que conoce la cultura.	Yolanda: Yes, today in [prenatal] class she was aggressive and impatient. She has everything one needs to be arrogant in this country. She is a Latina, but she acts like an American. We have no doubt: she lets everyone know she was born here, that her boyfriend is a *gringo*, that she knows the language, and that she knows the culture. (Fieldnotes)

The Latina MCCs' criticism is similar to Blacks' and Mexican-Americans' accusation against members of their own racial group of "acting white" (that is, a middle-class version of white) and abandoning their community (Bettie 2003). Yolanda's reaction shows how the existence of ungrateful Latinas was a threat to her moral identity. Latinas were supposed to be the neediest. If not, there was no need to protect them.

The view of the ideal Latina client reinforced the MCCs' view of "American" clients as "trouble." "Americans" and Latinas were often defined in contrast to one another. The MCCs claimed that "American" women complained, wasted their time, and "failed to show up." If they did show up, they often had an "attitude." "Americans" would, as one of the

MCCs put it, “step on their toes” and, most importantly, did not show appreciation of the MCCs. These expressions of anger by the “American” clients could potentially challenge the MCCs’ moral identity as health providers. However, they had the opposite effect. They made the MCCs more aware that their perseverance in the face of such difficulties indicated their actions were even more noble. A high-paying job in a clinic with a privileged clientele does not offer the same opportunities to feel good about one’s work. As much as the MCCs did not enjoy “difficult” clients, they would have had more difficulty wielding a moral identity without them.

Notions of the difficult, uppity, “strong, bitchy woman” (Collins 2004: 137), however, have been used as stereotypes and controlling images by whites of Blacks for generations. As Collins (2004: 138) explains, labeling Black women as difficult has been a way for white people to control and chastise poor and working-class Black women:

> Aggressive African American women create problems in the imperfectly desegregated post-civil rights era, because they are less likely to accept the terms of their subordination. In this context, Black “bitches” of all kind must be censured, especially those who complain about bad housing, poor schools, abusive partners, sexual harassment, as well as their own depiction in Black popular culture. They and their children must be depicted as unsuitable candidates for racial integration….[It] becomes a way of stigmatizing poor and working-class Black women who lack middle-class passivity and submissiveness.

In the process of labeling these women “problematic,” the MCCs overlooked Black women’s oppression. The MCCs failed to acknowledge these Black women’s limited control in and over their lives as they experienced economic and social powerlessness (Allan et al. 1993; Flynn and Fitzgibbon 1996). The MCCs had problems with both their “American” clients and the Black staff. Black staff and Black clients had seen Care Inc. move from serving a predominantly Black community—one that is still in need—to serving mostly

Latina/o clients. This Latina/o community is seen by Black staff and Black clients as a threat to scarce community health (and other) resources. The MCCs also avoided categorizing the tensions as race-based by relying on a rhetoric of "American" versus "Latina" instead. This allowed them to navigate around any feelings of racism (a real threat to their moral identity) and focus on lack of privilege by Latinas instead (where they were the protectors of those who could not protect themselves).

The inter-minority hostilities between Blacks and Latinas/os were mutually reinforcing. In the absence of a problem with Black staff, the "difficulties" with the "American" clients might not have seemed as burdensome to the MCCs. Likewise, in the absence of problems with "difficult Americans," the problems with staff might not have seemed as intense.

The MCCs believed that Latina clients needed more help. They saw Care Inc. as the only viable option for Latinas. According to Melanie:

> They [Americans] can get health care. A lot of our American clients qualify for Medicaid and they qualify for Medicare and there's tons of other places in the community that they can receive healthcare. I mean, not tons, but there's other places, you know? And we're really the only place around here that serves the Latino community. And, we have so many clients we don't know what to do with. (Fieldnotes)

Similarly, the Latina MCCs claimed that their "American" clients did not need a lot of counseling. Yolanda explained: "Yes, by the time they [Americans] see us, they already have their minds made up." (Field notes) The MCCs also maintained that their "American" clients had access to all the information they needed, and this assumption shaped the way they counseled these women. I wrote in my field notes how MariaTe gave the results of a pregnancy test to a 19-year-old Black woman:

> MariaTe: Why did you come in today? (talked slowly and softly)
>
> Ruth: I came to check if I am pregnant.

MariaTe: Are you taking contraceptives? Are you taking care of things?

Ruth: No. I do not take any birth control methods. I have a kidney problem, so I can't take any hormones, and we are going to decide with my doctor what contraception I might use.

MariaTe: Are you planning to get pregnant?

Ruth: No. Not really. But if I am, well, I guess, it will be welcomed.

MariaTe: The results indicate you are pregnant. (in a celebratory tone, congratulating her)

Ruth: Oh, OK.
(Ruth's eyes begin to water. She does not seem pleased with the news.)

MariaTe: Are you taking vitamins or folic acid?

Ruth: What is that?
(Ruth was shaking and tears began to fall down her face)

MariaTe: Folic Acid is a vitamin. It is good, and it prevents the baby from having problems when developing his spinal cord.

Ruth: No. I am not taking that.

MariaTe: Here, I will give you a sample bottle. Here at the clinic we offer prenatal care, do you want to get it here?

Ruth: Prenatal care?
(Ruth looks confused and overwhelmed)

MariaTe: Yes. You will be assigned an MCC, like me, and you will get medical care, WIC, and other state services. (she talked slowly)

Ruth: I guess. (She moved her hands to her face and began to sob).

MariaTe: Are you OK? (concerned)

Ruth: Yes. (Ruth took a Kleenex and wiped her tears off her face)

MariaTe: Good, let's schedule the first prenatal.

When MariaTe returned, I asked, "Do you think she is OK with the news? She seemed a little shaken up by the results." MariaTe responded (her tone was concerned), "I know. Do you think I should have talked to her about abortion? But she said it would be welcomed. Well, she is American, she has all that information." MariaTe did not discuss all the options with Ruth: staying pregnant, putting the newborn up for adoption, or obtaining an abortion. Ruth appeared confused and overwhelmed with the news of being pregnant, but MariaTe ignored it. MariaTe seemed to focus only on Ruth's literal responses: "I guess it will be welcomed"; and "OK." Because MariaTe did not inform her of all her options, including abortion, MariaTe could not ask Ruth (if Ruth were to decide to terminate the pregnancy) whether she would have trouble getting access to the cash needed to pay for an abortion. MariaTe assumed that all "Americans"—regardless of their race, age and class—have access to information about abortion. Confronted with evidence that she provided sub-par service, MariaTe said that her actions were commensurate with the client's level of need (and maintained her positive sense of self at the same time).

This moral identity required the MCC's to provide excellentservice to needier clients. Consider how MariaTe informed a Latina of her right to have an abortion. I recorded the following conversation between MariaTe and Cheli, a Latina who waited in MariaTe's office for the pregnancy test results:

> MariaTe: Remember you have more options. You can always abort.
>
> Cheli: (looking at MariaTe, talking fast) Oh no! If I am pregnant I will have it. As you know, I lost one, and that is very hard. I do not know if I can handle an abortion.
>
> MariaTe: (talking slowly, putting her hand on Cheli's) It is your decision. I just wanted to give you options. But of course you can handle an abortion. It is your right to have an abortion. It can be the best option for you, since you are taking care of a newborn and also working.

After several minutes the lab technician called MariaTe to get the results of the ICON® test. When MariaTe returned, she said to Cheli:

> MariaTe: (talking softly, with her hand on Cheli's shoulder) We are going to schedule a prenatal visit. You are pregnant.
>
> Cheli: (crying) Poor baby.
>
> MariaTe: (with her hand on her shoulder, she spoke firmly) I repeat, you have other options. You can always abort…

The MCCs did not see many Black or white clients ; the majority of the women they counseled were Latinas. It would be unwise to generalize from Ruth's case, since I observed few MCC-Black women interactions. However, because MCCs considered "Americans" as privileged, as least relative to Latinas, MCCs may have been less likely to give particular information to non-Hispanic patients.

The MCCs frequently told me that they were the only ones who cared for and about Hispanics. For example, Yolanda shared her discontent with the services provided at another local community clinic to Hispanics. To Yolanda, Care Inc. was the only realistic option for Latina clients.

> You know, Hispanic clients complain a lot about [Clinic B]. They say that they are treated like dirt. …They are not good at giving information to the Latino women. I had one who called here asking for some information complaining that no one helped her. If they did not know the information, they should. And if they have the information, why don't they give it to them? And it is not because they are too busy. Their case load is lower than the one we have here. (Fieldnotes)

The white MCCs felt the same way. As Rachel said to me:

> I think Latinas are discriminated against all the time, in particular in the area of reproductive health. I know that many people say that it was much worse in their country where abortion is illegal. So yes, it is different here in the U.S., but not by much. Here [in the U.S.] Latinas still get denied access to medical services. Latinas have limited options on their reproductive choices.

> And Latinas have to face racism and discrimination daily when going to the hospitals, going to pharmacies, anywhere. So even if abortion is legal, for many Latinas, abortion is denied everyday (Fieldnotes).

When I asked Rachel about unfair treatment she thought her clients faced, she spoke only of Latinas. She said in an interview:

> I think there are more barriers for Hispanic women that do not speak English, or are not a resident of the State of North Carolina. If you do not speak English, in spite of the fact that it is a federal law that if you have a large percentage of people that speak a certain language that the County Social Service Agencies are supposed to have somebody that can serve as a translator or is preferably bilingual. Many of the counties are in violation of that federal law. When I call the hospital, even though a hospital swears up and down that they have many, many translators, oftentimes a woman will go there and there's not somebody available to help translate….

All the MCCs felt that Latinas and Latinos had no other health care options and were constant victims of bigotry and discrimination. The MCCs described Latinas as a "community that needs us." By helping the "neediest," the MCCs could feel good about themselves, regardless of how they talked about "Americans."

Maternal Care as a Feminist Mission

The final strategy used by the MCCs to enhance their moral identity was to define maternal care work as part of a feminist mission. For example, the MCCs often commented on how their services "improved women, infants and families' health and well-being" (Fieldnotes). The MCCs emphasized their good intentions for doing maternal care work by invoking the importance of empowering women. Even if they perceived non-Latina clients as having more options, they were still women. As Rachel explained to me: "Our job is to educate and to provide the best service and care we can to those we can serve. We

empower." (Fieldnotes). Melanie viewed her job as giving power to women by educating them. When I asked her in an interview to describe her work, she said:

> Pregnancy tests take up a lot of time, but they're actually one of my favorite things about my job. I think that when you do a pregnancy test it's what we call the teachable moment. It's just a really good opportunity to do good reproductive health counseling. Women are normally pretty receptive, and so I can do a lot of talking and teaching about contraceptive options. Even when doing options counseling to someone that is pregnant and is not sure if they want to keep the baby or not, which can be stressful, I enjoy talking to the women and helping them to think out their decisions, and helping them think about what they want to do and what the next step is going to be. For me, that's just something that I really like.

An important part of the MCCs' work was to clarify a woman's options: staying pregnant, putting the newborn up for adoption, or obtaining an abortion. The MCCs said that giving women knowledge about all the choices available to them granted women "freedom," "control," and "power." They constantly cited the help they offered women under difficult circumstances as evidence that their work was more than a job: it was a mission. Rachel emphasized the importance of offering abortion as an option to women:

> My view on abortion is very clear. Abortion is a way for women to have control over reproduction. Some women might use it as a method of birth control. For others it is what they do as their last resort. And others do it when there is a problem with the fetus, when there is a disability, or when the fetus dies. Abortion is about control. Abortion is a choice. I believe that women must have the choice to have an abortion, and therefore women must have knowledge about it. Knowledge is power; knowledge is liberty. (Fieldnotes)

MariaTe also thought of maternal care work as a mission. She said:

Si hay alguien que tiene una prueba de embarazo positiva y no quiere al bebe, que tu estés allí para ayudarla, apoyarla en lo que ella quiera, en lo que ella decida, sin juzgarla es lo mejor. Es el hecho de que haya alguien que este allí, con ella, mientras ella toma la decisión de aborto o no aborto. Nunca me imagine que pudiera ayudar tanto y que fuera tan necesaria esa

If there is someone with a positive pregnancy test, and she does not want the baby, then you are there to help her, to support her in what she wants, in what she decides, without judging her. That's the best. It's the opportunity that someone is there with her while she decides to abort or not. I never imagined how important this help is. For example, I had the case of a

ayuda. Por ejemplo, tuve el caso de una chavita que quería abortar y no tenia dinero. Se me hace padre poderle decir: bueno, podremos mover cosas para que consigas este dinero para esto.

teen that wanted to abort and did not have the money. I think it is great that I am able to tell her: OK, we will do things to help you get the money for this.

And Melanie said in an interview:

> I consider my work feminist work. I think feminism is helping women achieve what they want to achieve in life. Helping them meet goals and set goals and be able to make changes in their lives depending on what they want. And I do that.

She recognized the importance of giving information as "planting a seed," especially for Latinas:

> I have some clients who have had four babies and want to have a fifth because they *must* have a son. I don't agree with it. Why do they need to have the son? They don't. But how can I convince her she doesn't need a son? It is not my place to tell her that. It's not my place to tell her what to do. I can only provide to her new information, plant a seed, and get her to think about things. And the truth is that most of the time women choose to do things I – as a feminist-- disagree with. And there is not much I can do. I can only give her all the information I have for her to make an informed decision. (Interview)

Yet defining their work as feminist was double-edged. It became a source of frustration as well as value for the MCCs. As Melanie said: "Most of the time women choose to do things I–as a feminist—disagree with." Rachel, who also defined herself and her work as feminist, described in an interview the difficulties of empowering women and not creating dependence:

> It's a real fine line for the staff here to provide services and assistance without creating dependence. How do you empower somebody when the agency doesn't even speak the same language? And there are so many needs and issues, basic needs like food, clothing, and shelter. How do you get past that point of meeting those basic needs to say "You need to speak out, and you need to be political; these are services that you have a right to, that you should have a right to, you have the right to fight against discrimination!" So it's hard, I think, for the staff because the need is so great, we can't be everything to everybody, and if we try to be, we burn out; if we try to be [everything to

> everybody] also we're enabling. It's hard to know where to define that line…I think, sometimes, by making a lot of noise you can bring about change, but sometimes you need to back off.

"Dependent" clients were a threat to their moral identity because they exhibited more than just "need." Dependent clients can expecttoo much of the MCCs and prevent them from helping those who are willing to help themselves. When MCCs sensed dependence, they felt justified in "back[ing] off."

As long as the MCCs did not sense dependence, they saw themselves as advocates not only for clients, but for women in general. MariaTe also defined her work, in particular the education she provided, as feminist. When I interviewed her she said:

Yo me siento como feminista porque si creo que los roles del genero están muy mal distribuidos y porque creo que la mujer esta rezagada. Algo que me emputa y no lo puedo soportar es a una mujer sirviéndole a un hombre o a sus hijos hombres, a sus hijos en general hombres y mujeres. Siento que hago un esfuerzo por romper esos esquemas. Siento que en ese sentido de mi trabajo tengo oportunidad de hacer esas cosas porque cada que puedo trato de abrir luces de que no tienes que hace esto, y no tienes que tener hijos hoy, no tienes que quedarte en tu casa a trabajar, que tu esposo no tiene porque decidir tu vida, siento que en ese sentido mi trabajo me da oportunidad de mandar esos mensajes y que si pegan en una de diez ya la hice.	I feel like a feminist because I believe that gender roles are distributed very badly and because I believe that the woman is a subordinate. Something that infuriates me and I cannot support is a woman serving a man or her male children, or her children in general, male or female. I feel that I deliver an attack to break those gender schemes. I feel that in that sense of my work I have the opportunity to do those things because I tell women you do not have to do this, and you do not have to have children today, you do not have to stay in your house to work, that your husband does not have the right to decide your life. I feel that in that sense my work gives me the opportunity to send those messages, and if one out of ten gets it, I did it.

Later in the interview, MariaTe recognized the importance of doing feminist work with Latinas. She said:

En las clases prenatales [solo para Latinas] constantemente tengo la oportunidad de estar repitiendo el mensaje, repitiendo el mensaje, repitiendo el mensaje. En las clases les digo: no tienes que quedarte en tu	In the prenatal classes [only for Latinas] I have the opportunity to repeat the message, repeat the message, repeat the message. In the classes I tell them: you do not have to stay in your house to work and your

casa a trabajar y que tu esposo no tiene porque decidir tu vida	husband does not have the right to decide your life.

The MCCs recognized the difficulties of doing maternity care at Care Inc. and often saw their work as a band-aid, not a cure. They did not see their work as capable of ending gender inequality, but as a positive force in a long struggle. The distance separating their current position and their ultimate goal actually helped them maintain their moral identity. Without a struggle, their mission became merely a job. The rhetoric of the feminist movement was an important tool to maintain a sense of themselves as good people.

DISCUSSION

According to *Healthy People 2010*[25], it is a national priority to eliminate U.S. racial and ethnic health disparities by 2010. Despite this national priority, the health-care industry continues to be commodified (Diamond 1992). As Nakano Glenn (2000: 85) notes, "there has been a shift of some portion of caring to publicly organized settings, whether administered by state, non-profit, or for-profit entities." And, the U.S. government is reducing public funding for social services and transferring the responsibility of care onto "the community." "Community" becomes a euphemism for the caring work of women (Finch and Groves 1983; Diamond 1984; 1992).

At Care Inc., the MCCs attempted to care for women's needs within "an industry characterized by practices that try to minimize labor costs by hiring part-time staff…and

[25] *Healthy People 2010* is a set of health objectives for the residents of the U.S. to achieve by 2010. It builds on past initiatives set in the 1979 Surgeon General's Report, *Healthy People*, and *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* (See: http://www.healthypeople.gov/Publications/)

floating…[medical] assistants" (Diamond 1992). Such labor arrangements are not surprising. As Nakano Glenn (2000: 86) explains:

> when care work is done by people who are accorded little status and respect in the society by reason of race, class, or immigrant status, it further reinforces the view of caring as low-skilled "dirty" work. This dual devaluation—of care work and care workers—rationalizes the low wages and lack of benefits that characterize care work.

The difficult conditions of their work, as well as the low status of their positions, only added to the MCCs' challenges and made their moral identity (being health care providers who helped the neediest of the needy) even more important. They maintained meaning in their work by positioning Latinas—but not Black or white clients—as those who needed them the most, and becoming advocates for them. The MCCs acknowledged that working with poor Latinas as low-status immigrants could damage their work's prestige. However, their commitment to Latinas became a symbol of their dedication to fight against racism and sexism: they worked day-in and day-out with Latinas in spite of their clients' stigma. The MCCs believed that they were doing important work because they cared for Latinas. Working at a community clinic provided the MCCs with the resources to maintain their moral identity because of the seeming insurmountable challenges they endured.

Their moral identity relied upon interpreting their work as a mission, not a job. This concept was delicately held together, in part, by the behavior of the clients. Whether or not the clients acted with "gratitude or attitude" (Stein 1989) was beyond the MCCs' control. They saw the women who came to Care Inc. for maternal care as responsible for their own behavior. Although demographic changes in the wider community may have fostered resentment among Black clients and staff, "difficult Americans" were seen as ungrateful and not among the "neediest." To the MCCs, the Latinas were the ideal clients. The attitude

from “American” women elicited the MCCs’ anger and indignation, while the gratitude shown by Latinas elicited the MCCs’ appreciation.

So, why did the MCCs place “American” women in a position of class and race privilege when compared to Latinas, and create distinctions among their needy clients? Why not embrace <u>all</u> of them as needy? Working at Care Inc. provided the MCCs with the resources to maintain their health provider role as a moral identity because all of their clients were poor or lacked insurance. Why create a hierarchy of need?

I argue that the MCCs faced multiple dilemmas: they had to deal with ongoing racial problems and inter-minority hostilities at the clinic, especially between the Black and Latina staff. Because of these racialized tensions, the MCCs focused on caring for Latinas. The Latina and white MCCs ended up seeing Latina clients as those they should“sav e” from Black staff, thus reinforcing their moral identity. It's not that the white and Latina MCCs were against Blacks, but that they saw themselves as those called upon to 'save' Latinas from Blacks who were prejudiced against them. Under these conditions, differential service did not threaten their moral identity, it emboldened it. By seeing Black patients as (relatively) privileged, the MCCs saw themselves as doing whatever they could to protect a vulnerable population (Latinas). In this context, both “American” and “Latina” communities felt under siege. The MCCs acted not out of malice, but instead exercised an unspoken triage of their own: Who was the neediest of the needy?

The white MCCs identified with the Latina MCCs and against the Black staff (and Black clients), even though the word they used to describe those clients was “American.” Why? Aren’t the white MCCs “American”? I argue that the white MCCs adopted the Latina MCCs’ language of “American” because, in this context, "American" operated as a synonym or code

for Black U.S. women. By using the language of "American," white and Latina MCCs hid the fact that it was really Blacks they were referring to, which in turn allowed them to deny that their perceptions were racialized. Using the concept of "American" was a way for the Latina MCCs to deal with how Black staff (and clients) treated them. It was also a way for the white MCCs to build solidarity with the Latina MCCs and complain about their Black clients without having to worry about their remarks sounding racist. White MCCs' moral identity (like the Latina MCCs' moral identity) was contingent upon "grateful" clients. "American" clients threatened that identity. In response, the white MCCs sought out "needier" clients to feel better about their work.

The obstacles in their path transformed this work into a feminist mission. Their feminist rhetoric maintained the MCCs' moral identity and self-worth: they were good people because they cared for those they saw as the most oppressed. The rhetoric of "feminist mission" helped the MCCs to perceive Latinas, as one of the MCCs told me, as the "most underserved of the underserved." The feminist ideology helped the MCCs justify being allies for and saviors of Latinas. At the same time the MCCs divided their clients along ethnic and racial lines, keeping these women from building coalitions based on shared class and gender inequalities. For the most part, they did not realize thatthey talked differently about their Latina and Black clients. Ultimately, however, privileging Latinas hindered their feminist mission of empowering all women.

At Care Inc., the MCCs exaggerated the differences between their "American" and "Latina" clients, in particular the differences between Black women and Latinas. Thus, the MCCs unintentionally considered less important the daily struggles of their Black clients as they focused on the community that they saw as needing them the most: Latinas/os. The

MCCs' racialized coding—"Americans" and "Latinas"—reinforced their views of who were the most deserving clients. By linking the term "American" to "privileged" and "difficult" clients, the MCCs failed to acknowledge the oppression of Black women.

This pattern of progressive people failing to notice how they inadvertently reinforce the inequalities in their midst has been found in other groups and organizations. Kleinman (1996), in her ethnography of an alternative health center, found that the (white) men "saw themselves as having transcended the divisions created by gender, credentials, and social class…But…social and economic arrangements…as well as ingrained ideas about gender and credentials led members to treat each other *un*equally" (124). She found that the male practitioners were at the top while the staff and volunteer women were at the bottom of what was supposed to be a non-hierarchical organization. The men in this center had most of the power and influence, and were revered and cared for by the women who served as the staff and volunteers. These women were grateful to have the opportunity to care for the men that benefited from these arrangements. Kleinman (1996) found that inequities were masked, in part, because members shared a moral identity that made them feel good about themselves. As Kleinman wrote (1996:138):

> Participants in progressive social movements may believe, like members of Renewal, that taking on the moral identity of leftist, antiracist, or feminist is enough. Participants may assume that membership in the group guarantees that they have purged themselves of the sexism (or racism, classism, heterosexism) that permeates the society "out there." But as the case of Renewal shows, people cannot will away years of ingrained ideas about who deserves more respect, resources, and affection. Many inequalities may thus be reproduced beneath conscious awareness.

This happens too within Black groups and organizations. Elaine Brown (1992), in her memoir "A Taste of Power: A Black Woman's Story," describes the sexist acts of men in the Black Power movement. The Black (heterosexual) men privileged challenging white racism

and reduced the importance of sexism and other inequalities. Black activist women responded by forming antiracist movements in which gender inequalities were considered fundamental.

It is important for progressive groups of people and organizations to analyze how their identities reinforce inequalities. At Care Inc., the MCCs' investment in their identity of caring for the "neediest of the needy" blinded them from seeing that non-Hispanic clients were poor and uninsured. It also lead the MCCs to unintentionally deny inequalities of race experienced by their "American" (Black) clients. Therefore, as Kleinman concludes (1996:140) it is important for people to see their identities "as a symbol of a lifetime commitment to critical self-reflection and radical action…Without such self-examination we may think of ourselves as progressive, but fail to build a better alternative."

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CHAPTER 3

"IT TAKES A SPECIAL KIND OF PERSON TO WORK IN THE TRENCHES": SOLIDARITY-TALK AT A COMMUNITY CLINIC

People can improve solidarity by sharing common wants, viewpoints, opinions, and attitudes (Brown and Levinson 1978). Although difficult working conditions can make achieving solidarity more challenging, workers can communicate ideas and commiserate in order to cultivate feelings of unity and cohesion (Eder 1988).

Noticeable status differences among people, however, can weaken solidarity. Consequently, people in high-status positions who are interested in having solidarity with those in low-status positions may minimize status differences between themselves and low-status co-workers (Eder and Sanford 1986; Goodwin 1982). In her ethnography of "Renewal," a holistic health center, Kleinman (1996) found this to be the case. In that organization, the practitioners (mostly men) had most of the power and influence, and were revered and cared for by the female staff and volunteers. Despite the fact that these women were granted less respect and earned little, they were not upset by this arrangement. In fact, they were grateful for the opportunity to assist the men who benefited from this set-up. Kleinman argued that inequities were masked, in part, because members believed "that all of them — practitioners and staff — were *in the same boat*" (14; italics in the original). Renewal's members built solidarity by focusing on their shared mission (maintaining an alternative organization) and down-playing any notions of unfairness. They used their shared predicament — staying afloat in the midst of a budget crisis — as a resource to feel both

special and connected to one another. In this chapter I will analyze how white, high-status staff at "Care Inc.," a community clinic where I did participant observation for a year and a half, also attempted to build solidarity in the face of dwindling funds and increasing racial tension between the Black and Latina staff members.

Care Inc. was situated in a low-income community where affordable health care and clinic jobs were rare. Racial, ethnic, and class divisions permeated the staff: white people dominated the high-status and higher paid jobs in the clinic, while Latinas and Black women performed the majority of the lower-paid and less-skilled jobs. This is representative of a larger split labor market where less lucrative jobs are held by Black and Latina/o workers while higher-paying slots are taken up by white workers (Bonacich 1972; Collins 2000; Conley 1999; Giddens [1981] 2001; Grusky and Sorensen; Wilson 1978, 1987, 1996). This highly stratified, race-class system explains, in part, the high levels of poverty among oppressed racial and ethnic groups (Bonacich 1972; Collins 2000; Wilson 1987, 1996). Stratification — by race, ethnicity, or sex — creates divisions among workers and weakens their power against the higher-ups, making collective action on the part of workers more difficult (Feagin 1991; Wilson 1978, 1987, 1996).

At Care Inc., the twelve high-status staff — all but one of whom were white — responded to tensions within the clinic by making appeals for group solidarity (as the basis of being good people doing hard work). However, these symbolic efforts failed to address the fundamental causes of staff tension: changing racial demographics in the community, the emergence of Spanish as a primary language in the clinic, and the limited opportunities for other jobs for low-status staff outside the clinic because of prevailing racial and class oppression.

Black female staff watched as the clientele shifted from eighty-percent Black to over sixty-percent Latina/o in a matter of years. They felt that Latinas/os were "taking over," and feared for their jobs because they lacked Spanish language skills. Latina staff, for their part, believed that the Black staff had the "ear of the white managers and administrators," and felt mistreated by Black staff who in effect acted as their supervisors. They accused the Black staff of being "racist," "bossy," and "uppity." They felt the Black staff doubled their workload by relying on them for translations. In turn, the Black staff felt disrespected, criticized, and excluded from staff conversations in Spanish. When the Black staff suggested that only English be used at the clinic outside of dealings with patients, and the clinic's lead doctor agreed, the Latina staff felt betrayed and insulted; more tension ensued.

Although the white, high-status staff in the clinic were sought out to resolve disputes, they were relatively sheltered from the conflicts between low-status Black and Latina staff. This was due, in part, to their physical segregation in other parts of the clinic, as well as the high regard the low-status (Black and Latina) staff granted them for sacrificing more lucrative jobs elsewhere and staying to help serve the poor. By passing up higher pay to help the poor Black and Latina/o clientele of the clinic, the high-status white staff earned a "moral" wage[26], [27] that consisted of esteem and sympathy (from the staff and community) and a positive self-conception in lieu of a higher salary. High status whites in the clinic were

[26] The idea of a "moral" wage is related to DuBois' concept of a "psychic wage" where he argued that, during reconstruction, lower-class whites would accept low wages from white elites in exchange for community esteem and freedom from constant violence: "It must be remembered that the white group of laborers, while they received a low wage, were compensated in part by a sort of public and psychological wage. They were given public deference and titles of courtesy because they were white. They were admitted freely with all classes of white people to public functions, public parks, and the best schools" (Dubois 1965: 700).

[27] I am grateful to Ken Kolb for suggesting this term and the reference to DuBois.

seen by the staff (and themselves) as moderators and not participants in the racial tension of the clinic (regarded as a problem between the low-status Blacks and Latinas). They were buffered both by their race <u>and</u> their occupational position as high-status workers.

When racialized tensions ran high at the clinic, the local managers and administrators of Care, Inc. organized a mandatory conflict resolution session facilitated by two outsiders (a Black woman and a Latina). The "diversity training session" was promoted by the white Human Resource Coordinator and the lead doctor as an occasion to "air grievances" and remind each other that clinic conflicts were a consequence of working "in the trenches" and helping the people most in need.

The white, high-status staff pleaded for "respect" among all workers. Their appeals for solidarity assumed that the conflicts resulted from structural constraints (such as financial problems) and the prejudices of, in their words, "a few bad apples." The high-status workers argued all staff faced social, political, and economic constraints. As we will see later, they argued that, while making life more difficult, these constraintsmade their work even more meaningful and important. These (real) structural constraints, therefore, offered potential resources with which all staff (Black, Latina, and white workers) could fashion identities as good health practitioners. But, as I will show, this type of solidarity talk was ineffective because the staff did not uniformly experience the same social, political, and economic constraints. While job challenges helped Latinas and Blacks establish solidarity within their own race, their hostilities towards each other inhibited efforts to see their shared interests and foster unity.

The white high-status staff had the resources to fashion an image of themselves as virtuous people making a difference in the world. They created a moral identity: a sense of themselves as good people by virtue of their work. Kleinman defines moral identity as:

> An identity that people invest with moral significance; our belief in ourselves as good people depends on whether we think our actions and reactions are consistent with that identity. By this definition, any identity that testifies to a person's good character can be a moral identity, such as mother, Christian, breadwinner, or feminist (1996:5).

While the white, high-status staff were successful at fashioning a moral identity that helped them feel good despite clinic tensions, the low-status staff had a tougher time. The Black staff could not build their identity as good people who helped their community because of the diminishing number of Black clients they served. The Black staff might have built their moral identity by helping Latina/o clients. But they could not because of the racial tension and fierce competition for local social services. And while the Latina staff were able to feel they were helping their own community, they could not feel in solidarity with the Black staff (who they felt were unfairly advantaged and treated them poorly).

My discussion will focus on the rhetorics used by high-status staff at a "diversity workshop" and their characterizations of the clinic's difficulties. I will analyze the white, high-status staff's attempt to relieve tension in the clinic with solidarity-talk and use of symbolic gestures. I will then explain why these attempts failed because they require similar racial and class identities among group members in order to be effective. The strategy employed by the white, high-status staff in the clinic also ignored the significance of race in interactions among staff members and allowed them to distance themselves from the race "debate." I will argue that the racial tensions in the clinic could not be fixed by rhetorics of

mutual respect, moral identity, and group solidarity without being accompanied by tangible changes in clinic policy.

SETTING

As a community clinic, Care Inc. provided health services to the neediest people in the surrounding towns and counties. The services offered at the clinic were "comprehensive," including primary and preventive care for children, teens, adults and older people, physical exams, laboratory tests, and flu shots. Care Inc. also offered nutritional services: Women, Infant, and Child Nutrition Program or WIC, and Nutritional and Dietary counseling. Clients had access to a pharmacy and dental services (terminated in October of 2002 but re-opened in December of 2003).

There were approximately 40 employees at Care Inc. (13 were white, 14 were Black, and 12 were Latinas). Ninety-five percent of the employees were women; only two men worked at the clinic during my fieldwork. The employees' ages ranged from mid-twenties to over sixty; however, most employees were in their thirties, forties, and fifties. While I was at the clinic some workers were moved to other clinics (e.g., the three staff who worked at the dental office that was closed in October of 2002). Two staff members from other clinics also came to work at Care Inc. Two others quit (or were put on two-week notice by the center manager), and five new staff members were hired.

Although the racial makeup was balanced numerically, the high-status staff (i.e., center manager, clinicians, human resource coordinator, and unit directors) were all white. There were two exceptions, however, the Black executive director and a part-time Black female doctor at the clinic (who left to work in private practice in December 2003). Mr. Mackenzie,

the executive director, had an off-site office. During the year and a half of fieldwork I saw him only twice: when I asked him for permission to do fieldwork and at the “diversity workshop.”

METHODS

I was both a participant observer and a volunteer at Care Inc. As a volunteer I “floated” through four of the six units. I am fluent in Spanish and English and translated as part of my volunteer work. I observed and worked with the staff at the front desk, the maternity care coordination program, the WIC and Nutrition department, and the clinical unit. For example, at the front desk I worked as a receptionist and client care coordinator, registered clients, and searched for medical records. In the clinic area I translated for clients while I observed the medical assistants, nurses, and doctors in action. The activities of a volunteer were well-suited to the job of observer. I hung around without being in the way, listened to and participated in conversations with staff and clients, and watched their daily routines. In the year and a half I did fieldwork (May 2002 to December 2003) I visited the clinic three days a week for five to six hours a day.

This study is grounded in the interactionist perspective in sociology (Blumer, 1969[28]). I also used the approach of grounded theory (Charmaz 2000). As a symbolic interactionist (Blumer, 1969) and feminist (Frye 1983; Bartky 1990) I studied how staff came to act as they did as well as the consequences of their behavior for reinforcing or challenging inequality

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[28] My study is also multicultural in that it acknowledges that women, depending on race, ethnicity, class, sexual preference, age, religion, educational attainment, occupation, marital status, health status, etc., experience oppression differently. It is also global in that it recognizes that women experience oppression differently depending on whether they are citizens of a First or Third World nation (Tong 1998: 212).

(Schwalbe et al. 2000). As a critical feminist I explored issues of power in contemporary racial/ethnic and gender hierarchies with a commitment to challenging racist and sexist ideology. These theoretical and political commitments informed my practice in the field and my analysis.

After each day at Care Inc. I wrote detailed field notes. I began analyzing the data by writing notes-on-notes (Kleinman and Copp 1993) and then analytic memos (Lofland and Lofland 1995). Collecting and analyzing the data simultaneously allowed me to test my explanations and modify my interview guide. I interviewed 21 of the 40 employees, including employees who worked at the front desk (center manager, reception, registration, client care coordination [or referrals], and billing, and medical records), clinical area (triage nurse, nurses station, laboratory, and doctors), Maternal Care Coordination program, and WIC and Nutrition Department. Nine of those I interviewed were white high-status staff: clinicians, unit directors, human resource administrator, and the center manager. I also interviewed five Black workers and six Latina staff. The interviews ranged from one to three hours. Most lasted one and a half hours. I collected documents produced or used by the health care providers, as well as flyers and brochures.

SOLIDARITY-TALK

The white high-status staff's solidarity talk consisted of the following: (1) defining health care provision as heroic work, (2) explaining problems in the clinic as inevitable and a consequence of structural constraints (e.g., "demographic changes," "resource insufficiencies," and "stress" in the workplace) that presumably affected everyone in the same way, and (3) assuming that conflicts resulted from the prejudices of "a few bad

apples." I will show how these rhetorics did not explain the persistence of a racially-based hierarchy of positions, or the level and focus of racial/ethnic tension between different groups at the clinic.

Defining Health Care Work as 'Heroic'

The white high-status staff's solidarity-talk defined all staff members' work — health care for the poor — as crucial. They implied that everyone at Care Inc. sacrificed equally for the higher good. The white high-status staff at Care Inc. often talked about the importance of providing health care services for "underserved populations." Dr. Koncord[29], the white lead doctor who had been working at Care Inc. for twenty-two years, told me in an interview:

> I always wanted to work in a community that doesn't have enough doctors; there aren't enough doctors per capita. But I particularly wanted to work with people from the lower socio-economic [class]. I didn't want to be in private practice and have the goal be just making a lot of money. I wanted to be able to be more focused on public service.

Dr. Toril echoed the importance of working at a community clinic:

> I always knew I wanted to do primary care and I also knew I wanted to do it with underserved people…[They are] people who have a hard time getting the medical care that they need either because of language barriers, cultural barriers, but most usually economic barriers. Why do any of us do anything altruistic? Ultimately it's because we want to feel needed…My clients might not get to see a doctor if they don't see me. I want to see people who might really not get medical care otherwise. They face significant barriers.

The white high-status staff, then, framed their work as a challenge they purposefully sought out because they saw it as a chance to "do good." For Gloria, the Physician Associate, working at the clinic allowed her to work on both primary health care for women and rural health. She explained in an interview how she viewed her work at the clinic:

[29] All names are pseudonyms. I gave staff only first names and used the title Dr. for physicians (and last names) because this was the way staff and clients referred to them.

> In the beginning I felt like I was doing good by providing medical care. And now I feel half of the doing good is just being in the room. It's when somebody is coming to you and talking to you, treating somebody with respect, listening, touching, being compassionate, empathetic. A lot of healing can just happen right there. And then the medicine helps. I like that we have the subsidized pharmacy, which makes a big difference. I feel we can try to work with people, keeping them happier than they would be if they didn't come to us.

For Gloria, Care Inc. provided her the means to promote a more holistic approach to health care than many of the patients would find otherwise. It also gave her a chance to work with clientele who would be appreciative and grateful for her help.

Mr. Mackenzie, the Black executive director whose office was located outside the clinic, talked about how the clinic was "making history." He reminded the staff at the "diversity workshop" how important it was for them to see themselves doing "something bigger than [themselves]." He continued to say that "our mission is the same: take care of people in need." Mr. Mackenzie stressed how the work of providing health care to the poor was "historical," "ground breaking," and "important." He said:

> If we put on top of the list why we are here, we are here for people who need us. You are part of history: we are the largest employer of this community that takes people in need…It is hard work. Other folks are not trying. Others put up barriers and they leave it to us. We are "people caring for people." We have done it for 34 years and we are still doing it with less than adequate resources. (Field notes)

Mr. Mackenzie appealed to the staff to interpret their workplace concerns as a part of "heroic" work. As an executive director, it was in his interest for workers to see their jobs as important enough to put up with stress and tension. However, this tactic presumed that all workers experienced workplace problems in the same way. Although Mr. Mackenzie lacked race privilege, he had class privileges which afforded him options outside the clinic (allowing him to see the noble mission of the clinic as a challenge worthy of accepting). The low-

status staff did not share these options. Their jobs were the best they could hope for. Thus, being a "part of history" was not enough compensation to make up for (what they perceived as) unfair treatment in the clinic.

In the clinic's lunch room or during staff meetings, it was common to hear the human resource coordinator, center manager, or the head doctor (all white) echoing the executive director's words to each other, as well as to the low-status workers: "You have saved many people. You should be proud of the job you do and how you do it."

Such solidarity-talk might have promoted a sense of worth, decency, and goodness among health care providers because they worked at a community clinic. They provided the best medical care they could to the poor and disfranchised of North Carolina. Although such an appeal to worth and decency makes sense and seems justified, it was not as useful for other (low-status Black and Latina) workers because it presumed all staff purposefully sought out a challenging work environment that could make them feel good about themselves. The low-status staff did not have the luxury of passing up more lucrative work. They still saw themselves as good people doing important work, but they lacked the race and class resources needed to fashion a moral identity strong enough to tolerate unfair work conditions.

"Working in the Trenches": Structural Constraints and Normalizing Tension

The second rhetoric used by the white high-status staff in the clinic assumed that the tensions experienced by the Black and Latina workers resulted from unavoidable structural constraints (e.g., "demographic changes," "resource insufficiencies," and "stress" in the workplace). Presumably, these constraints shaped the day-to-day care done by all staff—white, Black, and Latina—to serve poor people in North Carolina. The white high-status

workers' allusions to these challenges suggested that difficult working conditions affected everyone in the same way (and were a consequence of working in the trenches and helping the people most in need).

Gloria told me in an interview that "working in the trenches" was what made her happy:

> I worked in international health research for 10 years. And then I came back to [Care Inc.] after being in international research. I wanted to get back into the trenches…it's the real world …you are in the hole; not only looking at the hole. I prefer being in the hole…I really enjoyed traveling and working in HIV prevention in Latin America and the Caribbean. It was wonderful work. But that was another time, and now it's this time, and I'm happy to be doing this.

For Gloria and others, working with the less privileged members of the community who might otherwise 'fall through the cracks' provided importance and gravitas to the work. They were on the front lines, seeing the daily impact of insurance policies and immigration reforms on human lives.

The white doctors assumed that "not everyone can do this work" because it "takes a special kind of person" to endure the difficulties of being community health care providers. Dr. Toril explained in an interview:

> I work there because I feel called to work there…God called me to medicine to the underserved. It's really what I've always wanted to do….. I think that the camaraderie that I have with most of my colleagues, especially the other providers, but many of the nurses too, it's kind of like being in the trenches together, kind of like the battlefield. This is an impossible, overwhelming job, but aren't we good people for getting it done…We're doing something worthwhile together.

For Dr. Toril and the other white high-status staff the (real) structural constraints were used to confirm their self-concept as "special," caring people. The series of conflicts —an overwhelming pace and too many things to do in a day's work —provided evidence of how everyone "ha[d] it so hard." By interpreting the clinic as a "battlefield," merely surviving

was seen as evidence of success (and worthy of feeling good about). The joy of survival, however, is amplified for those who altruistically volunteer for the assignment.

Resource Insufficiencies

The staff at Care Inc. worked under difficult conditions. The staff would have been paid more in a private organization. They were overworked, facing a continuous stream of clients. The white staff frequently talked about how Care Inc. provided health services to people in need and how the demand for health services at the clinic exceeded the center's capacity. Many times the white staff recalled how new clients had to wait three to six months to be seen.

In thirty-five years of the clinic's history, the staff doubled in size to respond to the growing and changing needs of the community. Despite this growth, Care Inc. was short-staffed. The workers faced an overwhelming pace and too many things to do in a day's work. All the health care workers experienced work overload and complained to each other (and to me) about it. In all the units I observed, staff performed several tasks at once, faced a constant flow of clients, and managed to meet more expectations than they could reasonably fulfill at one place and time. As one of the two receptionists told me, "the pace is relentless."

The white high-status staff in the clinic frequently mentioned how busy they were and how they did not have time to provide all the services needed by their clients. At a staff meeting, Teresa, the white WIC director, said that staff were "stressed out" by the staff shortages and that the situation "is made worse when staff is out or positions are vacant." She described what was said in the meeting in a memo sent to the administrators and unit directors (noting that this could be shared with anyone):

> It was clear from the staff meeting that [the clinic's] staff are feeling stressed by the staff shortages (medical assistant, registrar, and pending Center Manager)....This is clearly noted in the breakdown of the registration system. Since that position has been vacant, other staff have not been able…to get the job done.

White high-status staff, in these ways, stressed that the work load and job demands were overwhelming. Being "stressed out" was expected and unsurprising.

The impossible demands of their workplace were used to explain tension and staff frustrations. Instead of resenting these challenges, the white, high-status, clinic staff felt good about having <u>chosen</u>, as one of them put it, "to work in the trenches." The working conditions, while materially difficult, offered symbolic resources to build their moral identity (Kleinman 1996); that is, their identity as good people was based on their role as healthcare providers for the underserved. What they paid for in terms of reduced salary and limited clinic resources (compared to private practice) they were reimbursed with a "moral" wage.

For the white, high-status staff in the clinic, the growing demand for medical care signaled the importance of the work they did. For example Dr. Toril, a white clinician, said to me in an interview:

> … My clients have a really hard time getting an appointment with me. My appointments are booked for like six to eight weeks in advance…. And then they finally do get an appointment and they come in and then there's no place to sit…Part of the problem is that our clinic doesn't ever stop accepting new clients. If we were a private practice we'd say, "We've got as many clients as we can handle now, we're not going to enroll any new clients, I'm sorry, and you have to find another doctor." But there's not that other option for our clients, and so we keep taking new clients…So that's part of the problem, it's just the way that there's too much need and not enough resources, and that we're kind of swamped.

Refusing clients was not an option. Instead of seeing the increase of patients as a burden, Dr. Toril referred to it as a sign that work at Care Inc. was even more important.

A rise in client visits was, unfortunately, accompanied by shrinking federal support. In the early 1970s, Care Inc. was 100% federally funded; this occurred when funding community clinics was a priority of President Johnson's war on poverty. By 2004, Mr. Mackenzie explained at the retreat, federal grants covered only 24% of the clinic's budget. The cutbacks forced Care Inc., like other community clinics, to cut costs and to "move to self-sufficiency." Mr. Mackenzie explained what this meant for the clinic: "We need to collect from clients. If we don't, we would have to close the clinic's doors. No money, no clinic!" Here we see that the problems facing the clinic were not only serious, but they were getting worse. At the same time, the moral identity of the white, high-status staff in the clinic was bolstered. The level of structural constraints, for them, allowed them to feel good about themselves as people doing important work.

Dr. Toril boasted that she provided medical care to "people who face significant barriers" and thatthe clinic's staff cared for underserved people despite "the need outstrip[ing] our resources." These working conditions were a source of pride. For the low-status staff, these working conditions did not function in the same way. These structural constraints signaled more job insecurity and less affordable health care options for members of their own communities. Federal funding cuts may have helped the high-status, white staff see their sacrifices as more noble, but they reminded the Black and Latina workers how fragile their position in the clinic was (see Chapter 1).

Demographic changes

The white, high-status staff in the clinic interpreted the increasing percentage of Latina/o clients as an opportunity to help an entirely new population. Becky, the human resource coordinator, said to me in an email:

> The [clinic] has gone through a rapid change from being a primarily African-American clinic to today largely Hispanic, as evidenced by the most recent client numbers indicating that Hispanics make up 67% of the clients. As a community health center we respond to the clients who appear in our waiting room.

Similarly, Rachel, the white director of the Maternity Care Coordinators Unit (MCCs), stressed the importance of their Hispanic clients' need in relation to their "American" counterparts:

> …The question is: where is the direst need or the highest need area? There are many resources in this community for pregnant American women, so it's not such a priority for us to have a childbirth class in the clinic in English.… I really wish we could offer it, but the reality is that if we did, we would not have time to do other things and provide other very needed services. So, it is a matter of what is a priority. (Field notes)

By helping "the neediest of the needy," (see chapter 2), Rachel derived even more satisfaction from her work.

In addition to appeals to rally around the dire situation facing the clinic, the white, high-status staff invoked "the changing demographics" as an opportunity for solidarity among clinic workers. The fact that many of their Latina/o clients were undocumented provided them with an opportunity to help "needier" clients. They asserted that this made their work even more important. Dr. Koncord said in an interview:

> …when I first started working I would say there were virtually no Hispanic clients…Occasionally people would come in without translators but it was just very, very rare…In general people who came to the clinic were native born U.S…I would guess that at least 50% of the clients I see now are Hispanic, maybe more. On walk-in days it's almost 100%...I am happy that we're serving the Hispanic community. I think it's their right. It's good that we're doing that.

There was a clear need in the community for services targeting the growing Hispanic community. Care Inc.'s staff was working hard to fill that need, with limited resources. For the white high-status staff, this enabled positive feelings for the individuals providing the work. They saw it as a common ground from which group solidarity could emerge. However, the Black staff interpreted these same demographic changes as a threat to their jobs and their community, making it harder for them to feel thatthey were "in the same boat" as the white and Latina staff.

Stress

The white staff were aware that it was difficult for some staff (and clients) to adjust to the structural conditions—immigration, importance of Spanish language skills, and resource insufficiencies. They did acknowledge that the low-status Black and Latinaworkers were experiencing stress and frustration. Dr. Toril linked the staff's daily struggles to provide health care to the tensions at the clinic:

> I worry that we are talking about stress in the workplace, meaning that we work in a place where the need outstrips our resources. We're always being asked to do more, and more, and more, and more. And not just the doctors, the nurses, the receptionists, the pharmacist—everybody. And that stress and the tension that that brings, and the way that it makes people snap at each other…It's just a perfect setup for resentment.

At Care Inc., stress was the natural response to increasing structural constraints; "everybody" felt it. Stress in the workplace, Dr. Toril explained, went with the demands of each worker's role; for example, she described the receptionists as "up there all by themselves without support, being asked to do a really, really hard job." Becky, the white Human Resource coordinator, echoed in an interview how overworked everyone was: "Because we're so lean

everybody is very stressed out. Everybody is wearing three and four hats." Besides too much work, the needs of the clients were seen as overwhelming.

Dr. Faust also mentioned in an interview how stressful doing healthcare for the underserved was: "I think just because we do indigent medicine we deal with high stress stuff." She later elaborated:

> Dr. Faust: …[A] stressful day would be a day where a lot of patients came in with psychosocial issues which take a lot of time and you never feel like you do enough for them or give them the resources that they need. And those are hard days when you have three or four people who really needed, that you could have spent a lot of time with going through their social issues and just didn't have the time so you had to cut visits short and re-schedule and maybe not have gotten some of the time with them that you wanted.
>
> Natalia: What do you mean by psychosocial issues?
>
> Dr. Faust: Things like domestic violence, things like depression, their anxiety disorders or just issues where women are, especially Latino women tend to have a very different lifestyle here, you know where in Mexico their life was very social and they were up and moving around and always visiting other people. They can get very, very isolated in the United States and really not leave the house most days.

In an interview Dr. Koncord also mentioned how stressful it was to provide healthcare to the poor:

> …[I]t's pretty stressful to have 15 minutes to see someone and address so many issues. And I often felt a little bit over my head because family doctors shouldn't be seeing elderly people because there are a lot of more problems that an internist would see…And our patients have always been very reluctant to see specialists because they either don't have insurance or they don't want to go to the hospital or Medicare doesn't cover it. They might have Medicare but they don't have supplementary insurance. So, they really don't want to go to a specialist. They don't want to have a procedure done. So, I was handling more complex problems than I might have in a different setting. So, there was certainly a lot of stress with that.

It is true that speed-up and not turning away clients affected all the workers at Care Inc. However, it was harder for the low-status Black and Latina staff because they had fewer

resources to deal with the strains. As low-status workers, they were paid the worst, overworked, and dealt with high turnover. Dr. Koncord acknowledged this: "I wish that the clinic had the resources to pay people better and that salaries were—well, to pay people better and to hire more. The non-professional staff is really stressed out and understaffed and underpaid." In this context, low-status workers, in particular, felt besieged by the speed-up and volume of people they served on a daily basis; they were expected to perform several tasks at once while facing a continuous stream of clients. Unlike the high-status staff, the low-status staff could not physically segregated behind doors and curtains from the incoming clients who had to wait while being admitted and processed. Although clients were relieved to finally see a (white) doctor or clinician, the waiting room was a less enjoyable place. Their frustrations were often taken out on the low-status Black and Latina staff in their immediate presence.

Additionally, it was harder to feel good about workplace stress when budget cuts at Care Inc. were indicative of declining social services that their communities relied on. Unlike the high-status, white staff, Care Inc. clients were also members of the low-status staff's communities. Few white clients came to Care Inc. The white high-status staff were sheltered from the front lines of race and class inequality inside and outside the clinic. The low-status staff were forced to accept the challenge of decreased funding for social services.

Mr. Mackenzie did not work inside the clinic, but he did acknowledge that racial tension existed. As an executive director, it was his job to help solve workplace conflict. He did this, in part, by invoking the inevitability of stress and change during his speech at the "diversity workshop":

> We are going through a lot of changes, all out of necessity. I know the changes are pissing some of you off. We are not done with the changes. We

> try hard to be a family and to be there for people who need us…It ain't easy to merge people and culture. It is hard work. (Field notes)

For him, the frustration and conflicts at Care Inc. flowed from the sacrifice all workers made for the higher good: caring for the underserved in North Carolina. He drew on these conflicts to attempt to create and reinforce a sense of purpose among the workers at Care Inc. and to promote a sense of unity. However, how much people can sacrifice depends on the options and personal resources available to them. While the high-status, white staff at Care Inc. may have seen their job as a "calling," the low-status Blacks and Latinas saw it as part of a larger struggle that did not end when they returned home at the end of the day.

"A Few Bad Apples"

The white high-status staff also appealed for "tolerance," especially at the conflict resolution session. Their pleas for solidarity among workers assumed that the conflicts were incited by the racial prejudices of, as was said to me in interviews, "a few bad apples." The white high-status staff claimed that the conflict could be resolved if only workers would simply try to get along. The white high-status staff believed that if all the low-status workers could understand that the interpersonal conflicts stemmed from the difficult personalities and the racial prejudices of a few, things would improve (regardless of race and ethnicity).

One of the biggest points of contention among the Black and Latina staff was the increased use of Spanish in the clinic. The Black staff had complained to Dr. Koncord, and told her that they felt disrespected, criticized, and made fun of because they did not know (or were unwilling) to learn Spanish. Dr. Koncord listened to these complaints, and suggested during a staff meeting that English be spoken in such settings as the lunch room. The Latinas interpreted this policy change as a betrayal and further evidence that the Black staff had

disproportionate influence within the clinic. This tension was interpreted by the high-status, white staff in the clinic as evidence of clashing personalities and feelings of insecurity as a result of not being included in conversations.

For example, Dr. Koncord defined the tensions at Care Inc. as a product of the exclusion that some co-workers felt:

> The non-Hispanic staff of the clinic feels that when people are talking, they don't know what they are talking about. They don't know Spanish and they wonder if they are talking about them. They feel left out. Nobody feels comfortable in the lunch room, because they are speaking Spanish, and others, in other tables, are speaking English. Non-Spanish speaking people feel disrespected when Spanish is being spoken. They feel that they don't count, and that they are excluded intentionally.… Some non-Spanish people feeling like they have been here for a long time, and they fit in, and now they don't fit in anymore. And I have even heard that some English speakers feel that some co-workers criticize them for not knowing Spanish: "You have been working here for 5 years and why don't you speak Spanish." So, I think that mostly everyone wants to feel included and we tend to make each other feel excluded. (Field notes)

At Care Inc. all the high-status white staff spoke Spanish. The Black staff did not speak Spanish. So while Dr. Koncord referred to "non-Hispanic staff," she really meant only the low-status Black staff. However, she recognized that it went both ways: each group (Blacks and Latinas/os) felt excluded.

Eventually, Dr. Koncord acted as mediator and manager of what she interpreted as the fragile emotions of upset workers. She said that she felt that the "Spanish-speaking staff" misunderstood her intentions. She said that "they were never told they could not talk with each other in Spanish, although that is what they heard" (Field notes). She said:

> Hispanics feel they want to talk Spanish with each other…Hispanics also feel like they have been ridiculed by co-workers about their accent, and that people come up to them and say "stop talking that crap," and "talk in English." I also heard that clients sometimes treat them rudely because they don't talk good English, and I guess there is a sense that they do not have any power in the clinic. (Field notes)

In an attempt to address these issues, she wrote a letter to the staff. It read, in part:

> I was so struck in speaking with many of you, how deep the hurt and polarization runs. I was equally impressed by how similar everyone's needs and wishes are…I was struck by the unintended hurt caused by cultural misunderstandings. What gives me hope is that much of what we all want is the same: to feel included, to feel comfortable together and to share respect and power in our work community.

Dr. Koncord, again, focused on how both groups—non-Spanish-speaking and Spanish-speaking workers— had similar "feelings of exclusion." Both groups felt hurt and polarized.

It is not unusual for whites to define racial conflicts in emotional, individualistic, and apolitical terms (Bonilla-Silva 2003). When I asked Catherine, a young white social worker, about "the language issue" and the tensions among workers at the clinic, she said: "It is not racism. No one here, in my opinion, is a bad person. No one is racist. I think it is a problem of irreconcilable differences. It is all about personalities." Similarly, Liz, the newest white Center Manager, said: "In my opinion, the problem is the personality of some specific people. They are just difficult, and not easy to get along with, yet work together." And Becky, the white Human Resource Coordinator, explained: "I think that the complaints people have about some staff people—that by the way are very few—are things they do to anyone and everyone. It is what I would call equal opportunity rudeness." Becky implied that those few people were also rude to white high-status workers at the clinic. Dr. Koncord agreed:

> I believe that what is going on is, in part, the normal interpersonal conflict that arises in an organization…But these persons they are complaining about are rude to everyone, regardless of their race, or language [she laughs]. But many people are assuming that it is because of the racial differences. This is sad, but it is not about the differences…because they forget that they are not kind to anyone. (Fieldnotes)

Catherine, Liz, Becky, and Dr. Koncord described "the problem" as caused by the abrasive personalities of a small number of people. Becky, the Human Resource Coordinator, characterized the problem as caused by a "few bad apples." They described these people as difficult, not easy to get along with, and unkind to everyone. Individualizing the problem also functioned to quarantine the problem and assign blame to a few individuals.

When probed, Catherine, Liz, Becky, and Dr. Koncord identified the rude people as: "you know, the receptionist [that] people always complain about," "the triage nurse we had to let go," "the woman in medical records, who sometimes is difficult with co-workers," and "I have heard that some people have problems with the two medical assistants who do not speak Spanish, you know." They never mentioned the names of these five women, all of whom were Black. The white staff only referred to them by their roles. It is conceivable that the white staff failed to mention the workers' race to avoid appearing racist. The white staff also asserted that these women—the five "difficult" Black low-status staff—were rude to everyone. Yet, I never observed these five women talking back or being rude to white staff. These "problematic" women were only "difficult" with Latina co-workers and Latina/o clients.

The racial tension between Blacks and Latinas in the clinic affected the white staff, but they did not feel they were directly involved. Instead, they saw their role as peacekeepers. It took them some time to realize that racial conflict even existed in the clinic. For example, Dr. Faust, a white female doctor, said:

> When I found out there was a problem, I was absolutely shocked…I think that is going to be an ongoing issue when you have primarily Spanish-speaking staff that are mixing with people who do not want to learn Spanish, but who want to be able to understand what's going on around them and might feel a little paranoid about somebody speaking, you know, people speaking Spanish close by.

Although she does not mention them by name, it was understood that Dr. Faust was speaking about the Black staff. She also blamed these Black women for the tensions at the clinic because they “do not want to learn Spanish.” However, the high-status, white staff in the clinic did not directly intervene. No one was ever sanctioned for being “rude” to a co-worker.

The absence of tangible penalties can be explained, in part, by the same moral identity that allowed the high-status white staff to feel good about themselves and their work. This identity was dependent upon their ability to be caring, understanding, and forgiving. Sanctioning the ‘problematic’ staff, who were allBlack , might open them up to charges of being racist, unfair, and siding with one group at the other’s expense.

There was one instance in which a ‘problematic’ staff person was fired. This occurred only after the situation became extreme and involved direct harm to a (white) patient. The staff member was Stephanie, the Black triage nurse. She denied a white girl access to see a clinician just before the child began convulsing and had to be taken to a local hospital emergency room. Latina staff had previously lodged complaints about her with the center manager, the lead clinician, and the Human Resource coordinator. Latina/o clients lodged complaints as well, but it took several months and frequent complaints before she was reprimanded. Only after the director of an allied Hispanic organization documented the complaints he received about Care Inc. from Latina/o clients was Stephanie asked to meet with the lead clinician and strongly encouraged to “change.” She was ultimately fired. The racial tensions at Care Inc. were escalating and the administration felt they had to step in and take action.

Shortly after Stephanie's firing, Care Inc. organized a mandatory "diversity workshop" facilitated by two outsiders (a Black woman and a Latina). The white high-status staff, administrators, and Mr. Mackenzie dominated the talk. As it turned out, the session was a symbolic attempt to address the problems at the clinic but did not result in any real policy changes or assigning responsibility to anyone. Although the facilitators had numerous recommendations for the clinic once the workshop was completed, they told me afterwards in interviews that they were never solicited.

Loretta, the Black facilitator, shared with me a memo she prepared with some solutions she would have proposed to the administrators of the clinic (if they had asked):

> Need for cross-cultural and anti- oppression training among staff. There should be consistent consequences for treating co-workers and clients disrespectfully or rudely. These consequences should be evenly applied regardless of race/ethnicity, organizational status or position; The organization needs to diversify its staff at all levels but it should create rules that support all staff regardless of race or ethnicity getting needed help from existing staff until diversity exists; The line of authority for staff in the hierarchy should be respected. However, there needs to be sensitivity to and respect for client's need to relate to someone who *may* better understand their particular needs (italics in original); Staff needs to have a clear explanation of each other's role, and their job training and performance expectations.

The two facilitators, Loretta (a Black woman) and Elvia (Latina), were disappointed that their insights were not taken more seriously by Care Inc. Loretta reflected:

> They threw away this little bit of money and said to themselves: It's done now. …When I went back to follow up, for example, and gave them some of the implications of what people said and some of the things that I thought that they seriously could do that had no financial implications…It was almost like a courtesy meeting…Until they can get the commitment at the top to do certain things differently it's moot, 'cause certain things that are problematic really need the power and the influence of those folks at the top to really do something.

Elvia echoed this assessment in an interview:

> The exit interview got postponed. Didn't seem to be a top priority to get that information. They didn't want to hear what the problems were and what it took to start doing something to change the clinic. My perception was that [Care Inc.'s] attitude is a little bit "well, we're going to leave it in the hands of the local folks to follow up." That's sort of the message I got: "Don't expect us to call you except if we can make arrangements for this one meeting. So, thank you very much."

In interviews, Loretta and Elvia said that the white staff saw themselves as not a part of the race "problem" at the clinic (except as problem solvers). Elvia said:

> They [white staff] acted like it wasn't really their problem. One of the doctors was listening to the radio or something like that. A couple of times I felt like saying "you know, you are a big part of the problem!" Only the doctor that is in charge of the clinic, she seemed to really feel acutely that it was, in part, her responsibility to find the solution. And she looked pained a lot of the time to me. So, I feel like they were at a loss as to why there were problems (Interview).

Loretta had similar views of the white staff at the clinic:

> In terms of the whites that I met in the center, I really got a sense that they didn't see themselves as part of the problem…[The center manager] said that it is the Latinos' and the Blacks' problems that might need to be fixed, not that we have decisions that we can make at the top level that will help resolve some of this and that we [whites] have some role in it. I saw them more as outside. They were analyzing it from outside and seeing that there were things that needed to be fixed between the folks...They sat on the fence (Interview).

Loretta's and Elvia's comments affirm my observations of the white high-status staff at the clinic. The white high-status staff wanted the "diversity workshop" to create a space for low-status staff to "air grievances." However, simply talking about the problem and making appeals for solidarity based on a shared moral identity was not the same as committing to change or taking some responsibility for the problem.

DISCUSSION

As high-status staff, white workers had a greater ability to create institutional changes to

alleviate tensions than other staff. However, the job opportunities available to the high-status white staff outside the clinic (and their relative freedom from class and race oppression in their private lives) allowed them to interpret tensions and stress in the clinic as an inevitable aspect of working "in the trenches" and helping "the neediest of the needy."

They understood interpersonal conflicts as originating from structural constraints and difficult personalities, not racial or class inequalities (or unequal distribution of power). They framed the problems at the clinic as due to a few "bad apples." Instead, their solidarity-talk promoted an identity as good people (that is, providers helping the poor). They were doing good — even heroic — work in the face of significant obstacles, and, in this view, were all in the same boat.

The consequence of this strategy was that it did not implicate or hold them — as white people — accountable. The white high-status staff individualized the problem in ways that left structural arrangements intact. This perpetuated the white high-status staff's relative privilege in the clinic and did little to acknowledge the roots of the racial conflicts among the Blacks and Latinas inside the clinic and out in the local community.

The white high-status staff used rhetorics of solidarity that denied race and class inequalities inside and outside the clinic. When they talked about race they never talked about themselves — whites — as having a race. Inadvertently, their attempts to fix the racial problem amongst the Blacks and Latinas exacerbated racial tensions and preserved their positions of authority.

The Black and Latina staff, for their part, drew on the whites' moral identity talk (i.e., we are special because we serve the neediest) as a reason not to blame them for any problems in the clinic. The low-status staff believed that white doctors had more important things to do

than deal with petty conflicts. For example, when I asked Amanda, the Latina client care coordinator, why she did not complain to Dr. Koncord, she said:

> No, I don't like to get the doctor involved. They got too much already. You know, I mean, their job is not to worry about what's going on in the front desk. They got too much already. It's too much to deal with. I know her door is always open, she has made that very clear, and she is always willing to listen, but no need to bother her with problems with my co-workers. She already knows that my co-workers make fun of Hispanic clients and are always criticizing me and other Latinas. (Interview)

Solidarity-talk and claims to a moral identity had the effect of encouraging the low-status staff to keep their complaints mostly to themselves. However, this strategy ultimately kept existing divisions in place. Yet, when tensions ran high, the white staff felt they had to do something. At the "diversity workshop," the white high-status staff created a space for people to vent. But "talk" did not solve the problem. Loretta and Elvia came up with suggestions for concrete changes to alleviate the problems. But they were not considered.

Latina staff, for example, did not understand why the difficult staff (five Black workers) were not sanctioned or fired. Amanda, the Latina client care coordinator, complained that "este comportamiento no se porque lo toleran aquí. En otras partes donde yo he trabajado si yo o otra persona se comporta de esa manera, nos echan. [I don't understand why they tolerate this behavior. In other places I have worked if I or other people behaved that way we would be fired]." This feeling was echoed by other Latina staff. Tatiana, the Latina receptionist, said: "Si yo trabajara, como trabaja mi compañera, me despedirían [If I worked like my co-worker (Black receptionist) does, I would be fired]." Latina staff claimed that the white high-status staff, in particular the administrators, had a double standard — they believed that if they (the Latinas) acted in the same way they would lose their jobs.

For the Black staff, race and ethnicity were at the center of the problems they faced.

Black staff asserted that the Latina/o population dominated the clinic and had undue influence over the "primary" language spoken at Care Inc. Conversely, Latinas exaggerated the power Black women had both inside and outside the clinic. Latina staff rarely acknowledged white racism against Black people in the U.S.

The solutions proposed by a white staff member (e.g., increasing the use of English among staff) did not diminish the threat thatBlack women felt from the changing racial demographics of Care Inc. clientele. Thus, the Black staff could not base their moral identities on serving "their people" because most of the clients were their perceived rivals (Latinas/os).

Furthermore, these changes brought about the hiring of bilingual staff—again, mostly Latinas. These changes placed Black women's jobs in jeopardy and threatened the slightly increased status they had achieved. These realities and inequalities faced by the Black low-status staff could not simply be smoothed over by a rhetoric of respecting each other. The Black workers were at a structural disadvantage in the clinic that the white staff's solidarity-talk did little to address.

Similarly, Latina low-status staff's sense of trust and solidarity with their Black counterparts was inhibited by what they perceived as second-class treatment (aimed at them as well as Latina/o clients). In addition, Latina staff complained that the high-status white staff and administrators prioritized the Black staff's needs and wants. As a result, Latina staff claimed that their needs were secondary to those of the Black staff. Although Latina staff could base their moral identities on serving "their people," they felt they had to defend Latina/o clients against prejudiced Black staff at the clinic. Thus, this basis of their moral identity could build solidarity amongst Latinas/os, but not with the Black staff.

The white, high-status staff in the clinic did not purposefully omit race as an explanation for the conflicts at Care Inc. Still, white staff's solidarity-talk was not useful to the Black and Latina staff because it ignored how racism outside the clinic shaped interactions among the low-status staff.

The white staff's moral identity as health care providers who served the needy, a byproduct of their solidarity-talk, helped mask how the Black staff and the Latina staff were structurally vulnerable within Care Inc., while the most powerful positions were held by whites. The white high-status staff were the best paid, most respected, and least overworked. By sacrificing lucrative opportunities elsewhere, they could feel good about themselves. The white staff were also buffered from inter-group hostility because they were perceived as not being part of the racialized conflict and their high-status jobs were not in jeopardy (unlike those of the low-status staff, especially the Black women).

As a result, the white staff, like many other U.S. citizens, avoided political discussions about race and racism (Eliasoph et al. 1998). They explained away racial phenomena using a rhetoric of color-blindness (Bonilla-Silva 2003; Frankenberg 1999). As Bonilla-Silva put it: "[W]hites rationalize minorities' contemporary status as the product of market dynamics, [and] naturally occurring phenomena" (2003: 2). I argue that the white high-status staff did not want to 'touch' the issue of race. The white staff might have feared that they would be labeled racist if it looked like they sided with either the Blacks or the Latinas.

Other researchers have concluded that workers' commitment to a moral identity, which can be a byproduct of solidarity-talk, keeps them from seeing inequalities within the organization. Daphne Holden (1997) found that working conditions can make it difficult for volunteers in homeless shelters to maintain their sense of moral integrity. Holden found that

the volunteers' place within a shelter's hierarchy and the requirements of the job weakened their moral identity. Volunteers' success at feeling egalitarian depended on their ability to pretend that they were unaware of status differences between themselves and their clients. Similarly, at Care Inc. the white high-status staff's moral identity depended on not being aware of the status differences between themselves and the low-status Black and Latina staff.

Kleinman (1996) found that men in the holistic health center she studied believed that they had transcended social stratification and inequality in their lives and work. However, claiming the identity of 'progressive' or 'alternative' by itself did not alter the hierarchical social and economic order in the organization, nor do away with unexamined ideas about gender and credentials. She wrote (1996:138):

> Participants in progressive social movements may believe, like members of Renewal, that taking on the moral identity of leftist, antiracist, or feminist is enough. Participants may assume that membership in the group guarantees that they have purged themselves of the sexism (or racism, classism, heterosexism) that permeates the society "out there." But as the case of Renewal shows, people cannot will away years of ingrained ideas about who deserves more respect, resources, and affection. Many inequalities may thus be reproduced beneath conscious awareness.

Rhetorics of shared experience may increase the appearance of solidarity on the surface, but are less effective at addressing the root causes of inequality and tension.

However, the higher and low-status staff at Renewal did achieve solidarity in their shared vision and mission. This was not the case at Care Inc. Instead, at Renewal, all members shared the same racial and class identities. Unlike Care Inc., all of the practitioners and staff at Renewal were white and had access to middle-class resources (their sacrifices for the organization were a result of a conscious decision that could be reconsidered if need be).

It is important for groups of people and organizations to analyze how their efforts to construct solidarity and moral identities may unintentionally reinforce inequalities. For

example, as Elaine Brown (1992) describes in her memoir, *A Taste of Power: A Black Woman's Story*, many men within the Black Power movement appealed to racial unity while minimizing the existence of sexism and other inequalities in their activist work. In response, Black women, including activists like bell hooks (1989), Audre Lorde (1984) and Patricia Hill Collins (2000 [1991]), formed antiracist movements in which gender inequalities were considered fundamental. Such work fulfilled the concluding thoughts of Kleinman (1996), who noted the importance for people to see their identities "as a symbol of a lifetime commitment to critical self-reflection and radical action…Without such self-examination we may think of ourselves as progressive, but fail to build a better alternative" (140).

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CONCLUSION

In this dissertation I analyzed how health care workers responded to and reproduced inequalities of race, class, and gender in their interactions with each other and with poor clients, most of whom were Latinas/os. I examined these patterns in a setting in which staff members faced an overload of clients and understaffing.

The high-status staff, all but one of whom were white, provided medical care for the most underserved citizens in the community. In doing so, they challenged the idea that Latina/o immigrants were undeserving of subsidized medical treatment. They learned Spanish and traveled to Mexico (or other Spanish-speaking countries) to learn about other health care systems and cultures in an effort to accommodate the clinic's growing Spanish-speaking clientele. By most accounts, the Latina/o clients, many of whom had been discriminated against while seeking care from emergency rooms or other social service organizations, viewed the white high-status staff, the doctors in particular, as caring and good-natured people. In this community clinic, many Latina/o clients (and staff) found a space in which most of the white staff accepted them enthusiastically. For white staff members, "health care worker" served as a moral identity; they saw themselves as helping the neediest clients, and were routinely affirmed in that identity by most of their co-workers and clients.

For the Latina clients, many of whom lived isolated lives in the U.S., coming to the clinic allowed them to connect with people who had migrated from their home towns and

villages and to talk about some of the hardships they experienced in North Carolina. I often overheard Latinas giving *consejos* (advice) to each other. These *consejos* enabled many Latinas/os to deal with the difficult conditions of their lives.

As I indicated, especially in Chapter 1, Care Inc. was a setting in which racial, economic, and social struggles among whites, Blacks, and Latinas/os played out. For example, Black staff constructed boundaries between themselves and Latinas (another marginalized group) while defining themselves as morally superior. The Latinas also engaged in this process of "defensive othering" (Schwalbe et al. 2000: 422). Each defined members of the other group as lesser than themselves. Black staff felt threatened by the racial transformation of the clientele at Care Inc. from Black to Latina/o. In response to the changing demographic, Black staff complained that Latinas/os were "taking over" the clinic and chastised Latina clients as reckless breeders and abusers of the welfare state. In addition, they labeled Latina staff as "lazy." Ironically, these rhetorics are the same ones that white elites have used to denigrate Black women. Latina staff, in turn, criticized Black women for being "racist," "bossy," and "uppity." They overestimated the degree of power and influence that Black women wielded, both inside and outside the clinic.

In Chapter 2, I argued that the Maternity Care Coordinators (MCCs) fashioned a moral identity—akin to a social worker with a moral calling—that helped them feel good about their work in the face of difficult working conditions. Significantly, difficult working conditions became resources that reinforced the MCCs' view of themselves as heroic workers. Their claim to a moral identity was further enhanced by defining Latinas as those who needed them the most. But, in doing so, they othered Black clients, labeling them as difficult "Americans." Presumably, the "Americans" were less grateful for their help, while

the Latinas were grateful, respectful, and thus deserving. In defining themselves as allies to Latinas, they unintentionally masked the disadvantages of poor white and Black women in the U.S.

These dynamics corroborate previous research by Stein (1989), who found that volunteers in soup kitchens and food pantries expected their clients to express at least benign neutrality, and preferably thankfulness, toward them. Clients' expressions of gratitude confirmed the volunteers' generosity and their self-concept as caring people. Clients' expressions of anger, hostility, arrogance, defiance, or resentment challenged volunteers' moral identity (Kleinman 1996:5), that is, their sense of themselves as good people. As a result, the volunteers at the shelter and soup kitchens, like the MCCs at Care Inc., overlooked the inequalities within and outside the organization that gave rise to the complaints and criticism. Just as the "attitude" of homeless shelter residents might have been a response to the larger social context of racism and class inequality, the "attitude" of the Black clients toward the MCCs might have been a response to their lack of resources for health care, dignity, and self-respect within and beyond the clinic.

In Chapter 3, I analyzed how white high-status staff at "Care Inc." spoke in ways that might have built solidarity among all the staff. But working conditions and racial tensions between Latina and Black staff made it difficult for Blacks and Latinas to feel connected to each other. The white high-status staff claimed that all forty staff members were doing meaningful and important work in the midst of constraints. Whitehigh -status staff urged co-workers to unite in solidarity, as they were presumably all in the same boat. Their framing of the difficulties at Care Inc. kept them from seeing the significance of race in interactions among staff members.

Recognizing racism, sexism, and class inequality as systems that harm all people might have allowed *all* staff to see their stake in challenging capitalism, racism, and sexism. At Care Inc., Latinas claimed that racism harmed only them. Similarly, Black staff maintained that they were the true victims of racism. And the white high-status staff, now mostly seeing Latina/o immigrants at the clinic, saw themselves as caring for those who needed them the most. It was difficult for any category of staff to see the full picture of inequality.

This is not the way it had to be. The white high-status staff might have helped challenge the unequal hierarchy at the clinic thatshaped social relations there. The white staff, who held the most powerful positions, might have pushed for hiring people of color for some of the high-status jobs. They might have taken some of the responsibility for training and supervising low-status staff. Not requiring Blacks to supervise and train Latinas might have helped create solidarity among low-status staff. Similarly, the white staff might have requested that the administration give time off and pay for Spanish classes for the low-status staff. If Black staff perceived that their jobs were not in jeopardy, the low-status staff might have seen that they shared class and race interests. The Black and Latina staff might have seen that racism and class inequalities victimize all people of color, prompting them to explore avenues of solidarity based on shared interests.

Finally, research on how healthcare providers contribute to racial/ethnic, sex, and class disparities in care "is in its infancy" (van Ryn and Fu 2003: 249). Women of all races and classes (Williams 2002; Corea 1985), poor people, working class-people (Fiscella et al. 2002; 2000), racial and ethnic minorities (van Ryn and Fu 2003), sexual minorities (Mills and Weber 2004; Stevens 1996), and other marginalized groups have experienced discrimination at the hands of health and human service providers. There is ample evidence

supporting the conclusion that "the behavior of health and human service providers contribute to…differences in care and, thus, institutional discrimination" (van Ryn and Fu 2003: 248). According to van Ryn and Fu (2003: 249), providers, intentionally or unintentionally, mirror and reinforce societal messages regarding patients' worth, autonomy, capability, and merit.

Health researchers' explanations of inequalities in medical treatment are dominated by psychological (and individualistic) explanations. Most public health researchers examine how "race/ethnicity, gender and socioeconomic position…lead to the differential distribution of health risks" (Williams 2002). They also analyze how these categories affect people's health or affect the treatment given to them by health care providers. These researchers calculate differences in health risk between members of these categories or calculate the differences in "quality" or "effectiveness" of the treatment by female/male or white/Black or private/public providers. Public health researchers use these computations as evidence of the sexism and racism that pervade the health care system. What these studies have not done is examine how these inequalities are reproduced in patterns of behavior and meaning among staff and between staff and clients.

Broader contextual dynamics—namely, immigration, capitalism, and racism— played an important role in shaping interactions between Blacks and Latinas/os. For example, changes in the racial make-up of the staff and clients threatened Black female workers at Care Inc. and shaped how Black workers perceived and interacted with Latinas/os. I suggested that Black staff giving Latina staff "a piece of their mind" was a way for these Black women to assert a sense of control and dignity in the face of systematic inequality and white racism outside the clinic. Prejudice was not a "personality" problem of some Black staff but a result

of organizational conditions and racism and class inequalities outside the setting. These broader dynamics help explain why low-status staff—Latinas and Blacks—criticized and claimed status over each other. In short, without taking into account organizational arrangements within the clinic and the way external inequalites shape the daily-work and interactions of all actors, we will understand less about the reproduction of inequalities at Care Inc. and at other community clinics.

Small changes in the organization of the clinic might have helped Black and Latina staff develop solidarity and class consciousness. The day-to-day administration of the clinic might have been changed so as not to create the idea that Black and Latina staff were competing for limited resources. As I suggested earlier, the administrators might have allowed non-Spanish speakers (all Black staff) to take Spanish-classes, paid for by the clinic and provided during work time. The administrators, as those who make the final hiring decisions, might have institutionalized a hiring process that would actively seek people of color for middle and high-status positions. Since marked status differences among people can weaken solidarity, reducing a stratified race-class system is essential for building solidarity among workers.

A conscious decision to limit how broader contextual dynamics shape interactions among staff would also be important. For example a yearly anti-racism and anti-capitalist analysis workshop could be institutionalized. Change is possible only in the context of changed social *arrangements*. As Thompson (2001:313) contends,

> the emphasis [in effective anti-racism workshops] goes beyond promoting diversity to looking at traditional power structures and the ways institutional processes support hierarchy… [it] requires taking openly about what hinders cross-race alliances, scrutinizing the way power is distributed within an organization, and creating a more equitable environment.

In antiracism, as opposed to cultural diversity sessions, "trainers try to keep people focused on race" (Thompson 2001:318). In an anti-racism workshop, participants have the opportunity to understand how racism is operating in the U.S. and its institutions. In anti-racism workshops, participants explore cultural and institutional racism. They look at how racism functions in the context of institutionalized systems of power, oppression, and privileges. The goals of the anti-racist workshop include developing an anti-racist action plan to make communities good places for all to work and live.[30] At Care Inc. including a critique of the current immigration debate would be of outmost importance. Such discussion might help staff, in particular Black staff, to examine how capitalism and globalization (rather than undocumented immigrants) are responsible for poverty and job disclocation in U.S. Black communities. Only with this shift in blame would thetension between these two communities lessen. Only with a frank and critical discussion of racism, capitalism, globalization, and other broader dynamics might staff recognize their shared interests.

[30] For examples see: The Virginia Organizing Project's Dismantling Racism Workshop; The Peace Development Fund; and Byron Hurt workshop.

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