ROOTED IN THE PAST, BLIND TO THE PRESENT: HEALTH CARE

ADMINISTRATORS' PERCEIVED ROLE AND RESPONSE TO SPANISH-

SPEAKING IMMIGRANTS IN A NEW-SETTLEMENT COMMUNITY

by

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This study examines how health care administrators perceive Spanish-speaking immigrant growth in a city with little to no history of attracting immigrants but recently experiencing tremendous growth. Different communities are finding a need to adjust various institutions, organizations, and policies to meet the needs of newer groups, which often arrive in communities ill-equipped to deal with the structural and social changes necessary to serve them. This study investigates the ways one health care system's administrators frame the institution's role and response as the surrounding city is transformed into a new destination city. Their responses complicate existing understandings of how people discuss newly settled immigrant groups in an era of racial colorblindness, as this colorblindness often cloaks underlying racial prejudice. Administrators who expressed egalitarian understandings professionally often shifted to rigid racial boundaries in their private lives. Moving the color line based on the arena of

conversation challenges existing theories, which mark racial hierarchies as static lines demarcating divisions between two or three groups. Finally, administrators link the needs of Spanish-speaking patients to the health system's Mission Department, reinforcing cultural representations of this particular group as indigent and outside the mainstream services offered by the health care system.

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CHAPTER I

INTRODUCTION

It is 10 p.m. on a quiet Wednesday evening. The smell of industrial cleaning supplies and bodily fluids wafts through the halls and bounces off linoleum floors. All visitors left hours ago, but voices echoes down the hall as the nursing staff changes to the night shift. The hallway lights brightly shine through the room as "Esther," a nurse, enters the room, greeting "Amanda," an English-speaking patient. The two women laugh about the latest celebrity gossip on "Entertainment Tonight." After checking on Amanda, Esther completes her final check-in on "Juanita," Amanda's Spanish-speaking hospital roommate. Juanita knows this is her last chance to talk face-to-face with a nurse until Esther returns to the hospital the next morning. Esther is the only Spanish-speaking nurse on the Labor and Delivery floor and the only person with whom Juanita easily communicates. The two women speak briefly about Juanita's concerns: she has been on bed-rest for two weeks, with another two weeks until her due date. Juanita is tired, lonely, ready to have her baby and return to her family. Esther assures Juanita that she looks good, and she will check on her again tomorrow morning. Juanita is left to the night shift nurses, who neither speak Spanish nor bother to use the translator phone when they come to check on her. Juanita is isolated from medical care when Esther is not at work or is busy with other patients, unless her ten-year-old son visits and acts as her translator.

Intermittently throughout the day, and routinely at night, Juanita receives medical care by someone who can not speak to her in her native language or utters a few words loudly in a language she does not understand. In these moments Juanita does not understand what is happening to *her* body and whether she is being informed about

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mundane matters or something more serious. If her son visits, communication with nurses is easier but her personal boundaries are violated as he is exposed to intimate details about her health.

Juanita's situation is common for a subsection of patients receiving medical care across the United States. For those who do not speak English, medical care often involves negotiating language barriers and hiring practices (among other manifestations) that do not match community demographics. Juanita and other Spanish-speaking immigrants drawn to new immigrant destination cities find themselves in a compromising situation, lured by the availability of jobs but entering local communities unprepared for their arrival or settlement.

STATEMENT OF PROBLEM

Immigration is a contested issue in the United States, the subject of numerous town-hall meetings, public opinion polls, television reports, printed press coverage, and academic inquiries. While the contestation of immigration is not a new phenomenon, the 'Latinization' of immigration and its impact, particularly within new destination cities, is a relatively recent development. Newspaper headlines often recite stories about local debates on immigration reform measures or demographic transformations to landscapes resulting from a newly settled group. Immigration is a major political issue, as indicated by the heated and mixed reactions following the October 2007 Democratic national debate surrounding then New York Governor Eliot Spitzer's proposed distribution of driver's licenses to all immigrants, both authorized and unauthorized (e.g., Confessore 2007; Hakim 2007) or Arizona's SB1070, which requires the detainment of all suspected "unauthorized" persons until federal confirmation of status (Archibold 2010). Following

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the 2001 terrorist attacks on the World Trade Center, Pentagon, and the foiled attack

resulting in a crashed plane in Pennsylvania, debates on immigration shifted from issues

of job security, social service expenditures, and English as a Second Language (ESL)

classrooms to overt concerns for national safety. Politicians, political pundits, the media,

and the public at large debate the merits for and against immigration. However,

immigration is still occurring, and at an increasingly rapid rate to new locations across

the United States. Different communities are finding a need to adjust various institutions,

organizations, and policies to meet the needs of newer groups, which often arrive in

communities that are ill-equipped to deal with the structural and social changes necessary

to serve them. This project investigates ways administrators of one health care system

frame their role and response as the surrounding community is transformed into a new

destination city for Spanish-speaking settlers.

The public and private preoccupation with immigration, through its various

iterations, has been relatively consistent since the late 1850s in the United States. The

sociological literature surrounding immigration focuses on:

- the consequences (health, economic, psychological, coping, etc.) of immigration

  on the immigrant (Farley, Galves, Dickinson, and Perez 2005; Kim, Van Wye,

  Kerker, Thorpe, Frieden 2006; Peak and Weeks 2002);

- the context of reception of the receiving community (Bachmeier 2007; Peak and

  Weeks 2002);

- the impact of immigration on the local economy (Bernstein 2007);

- the settlement patterns of immigrants (Bachmeier 2007; Durand, Massey, and

  Zenteno 2001; Hardwick and Meacham 2005; Light 2006);

- the adaptation process of immigrants (Hirschman 1994; Portes and Rumbaut 1996; Portes and Zhou 1993);

- the demographics of immigrants (Bean, Corona, Tuiran, Woodrow-Lafield, and Hook 2001; Mather, Rivers, and Jacobsen 2005; Passel 2005; Passel, Hook, and Bean 2004; Passel 2006; Zavella 2000);

- and American public opinion toward immigration and particular immigrant groups (Chavez 2004; Pew Hispanic Center 2006a; Pew Hispanic Center 2006b).

Studies examining the impact of immigration on health care include:

- the health status of immigrants (Andalo 2004; Antecol and Bedard 2006; Farley, Galves, Dickinson, and Perez 2005; Kim et al 2006; Ponce, Nordyke, and Hirota 2005; Reardon-Anderson, Capps, and Fix 2002);

- the impact of community reception on health care utilization or health status (Peak and Weeks 2002);

- barriers to health care access (Bender, Clawson, Harlan, and Lopez 2004; Berk and Schur 2001; Documet and Sharma 2004);

- the utilization trends of immigrants (Leduc and Proulx 2004);

- the immigrants' perception of health care services (Searight 2003);

- the impact of immigration on health care expenditures (Fronstin 2005; Mohanty 2006; Mohanty, Woolhandler, Himmselstein, Pati, Carrasquillo, and Bor 2005);

- and how immigrants find health care services (Derose 2000; Devillanoa 2006; Morrison, Haldeman, Sudha, Gruber, and Bailey 2007).

This study contributes to existing literature on immigration and the sociology of health by examining how one health care system's administrators frame their role and response to

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new Spanish-speaking settlers. Rather than investigating the utilization trends of Spanish-speaking immigrants, the experiences of immigrants within health care, or health status indicators of immigrants, this study uniquely contributes to both immigration literature and race relations literature by complicating existing theoretical understandings of how people discuss newly settled immigrant groups in an era of racial colorblindness and in a community where the Confederate history is still deeply embedded and stakes in race relations are high.

Studying the relationship between immigration and the health care industry is not new; however, studying the topic from the perspective of administrators is a new contribution. As Thomas (2003) states, hospitals are locales with a dual-authority structure that are both administrative and medical; however, the trend within academic research on health disparities focuses only on the medical structure. The administrators within the health care system identify community needs, assess the health care system's role in meeting community needs, and decide whether or not to make adjustments in care delivery to meet those needs. The decisions made by administrators have real material consequences for seekers of health care services, including the availability and accessibility of needed services. For example, if a Spanish-speaking woman needs prenatal care but cannot find Spanish-speaking providers in her community, she may go without care, resulting in an increased risk of neonatal death, a low birth weight baby, maternal death resulting from delivery, and/or increased costs of neonatal intensive care services (Singh, Torres, and Forrest 1985; Guttermacher Institute 1986). However, administrators are also embedded in an era dominated by the ideology of racial

colorblindness, where to notice race risks being perceived as racist or as providing special benefits to particular race groups.

<div align="center">RESEARCH QUESTIONS</div>

Broadly, this study examines how health care administrators believe the industry is impacted by the recent growth of Spanish-speaking settlers in new destination cities. How is the health care industry adjusting as a result of new, Spanish-speaking settlers' population growth in new destination cities? How do the administrators perceive the institutions' role and response resulting from this new demographic growth? How do they perceive changes in the local community? The shift in settlement patterns to new destination cities follows decades of numerous push and pull factors on immigrants. Various institutions, including government, education, and commerce, embedded within new settlement communities grapple with how to adjust resources as a result of these new settlement patterns. This study investigates how administrators of "St. Peter's Seventon Health System,"[1] a not-for-profit, Catholic health care system in the Atlantic South, frame their role and response to the new waves of settlers arriving in "Seventon."[2] This is a community with a little to no Spanish-speaking population base but has been impacted by a large and recent growth (i.e., a "New Latino Destination" city and a "Pre-Emerging Gateway City").

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[1] St. Peter's Seventon Health System is a pseudonym for the studied health care system to comply with confidentiality agreements.

[2] Seventon is a pseudonym for the actual city. Identification of the city would allow for identification of the health care system.

OLD STORY IN A NEW ERA, WITH NEW TWISTS

The history of the United States is comprised of waves of public and political concern with immigration, from the Chinese Exclusion Act of 1882 to current debates regarding border security and control. The United States initially sought Mexican labor during the expansion of the American railroad system (Durand, Massey, and Zenteno 2001). The installation of reform measures to control immigrant influx provided a brief respite for White laborers' and White small business owners' xenophobic concerns of competition from new immigrant groups. The next fifty years represented high recruitment of Mexican laborers by the United States government to replace interrupted traditional labor sources developed following World War I and the resulting immigration legislation (The Emergency Quota Act of 1921 and the Immigration Act of 1924) (Durand, Massey, and Zenteno 2001; Portes and Rumbaut 1996). Strong, deliberate recruitment continued until the beginning of the Great Depression, which "ushered in an era of limited migration and massive deportations that persisted through the ensuing decade" (Durand, Massey, and Zenteno 2001: 109). The United States continued to vigilantly usher "unwanted" workers out of the country until labor supply shortages during World War II. The reversal of this policy led to the Bracero Accord of 1942, which represented a bilateral agreement between the United States and Mexico for short-term agricultural labor for Mexicans while Americans were deployed for World War II. The United States continued to install exceptions for Mexican laborers working in western agriculture throughout the immigration policies until the Immigration Reform and Control Act of 1986 (IRCA). The IRCA attempted to halt undocumented immigration by offering two provisions: an amnesty program for undocumented

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immigrants, and employer sanctions for repeated hiring of undocumented workers (Portes and Rumbaut 1996). The provisions within the IRCA were challenged and subsequently altered to include an amnesty program for "Special Agricultural Workers" (SAWs) and to prevent employers from validating worker documentation (Portes and Rumbaut 1996). Thus, the arrangement of labor supply, particularly for agricultural sites in the southwest United States, continued after the IRCA. The pattern of the United States luring workers from Mexico continues today, following historical relations between the two countries. The ebbs and flows of human migration are contingent upon the economic and political policies of the United States (Pedraza and Rumbaut 1996; Portes and Rumbaut 1996).

Migration, both internationally and nationally, is not new. The United States attracts more immigrants than any other nation. Immigration patterns fluctuate with the U.S. economy and international unrest. However, immigration today is different from the past in three key ways: who is coming, where people are going, and the volume of people. First, the face of U.S. immigration is changing following massive immigration policy shifts in 1965. Immigrants today arrive primarily from Asian and Latin American countries rather than Europe. Second, immigrants migrate and settle in communities rarely considered in the past, places like Seventon. Third, those same immigration reforms, which changed who immigrated also doubled immigration flows from the 1950s to the present day. In addition to changes in immigration policy and immigrant destination, the dominant racial ideology in the U.S. also shifted away from Jim Crow racism to racial colorblindness.

The Racialization Process

Race is widely understood as a social construction developed under modern human relations, based on perceived phenotype differences between people. Moreover, race, as a social construction, refutes early primordial understandings. In the United States, race has remained a relatively stable social division and hierarchical arrangement following the transatlantic slave trade, white Americans of European descent, occupying the highest position within the racial hierarchy.

As a social construction, race changes over geography and history. The racialization process, or process of creating race groups, has more recently been applied to Hispanics and Latinos in the United States. Indeed, Smelser, Williams and Mitchell's (2001) introduction to *America Becoming* include Hispanic (Latino) among the major race groups in the United States, alongside White, Black, Asian, and American Indian. Throughout this project I initially questioned administrators about Spanish-speaking patients but adopted whatever label they subsequently used. Labels included Hispanic, Latino, Mexican, Iberian, and Spanish-speaking. My use of Spanish-speaking throughout this project is not to suggest that Spanish-speaking settlers in Seventon were a unified group based on language ability, but to open the discussion about settlers beyond one particular geographic region. The racialization of Spanish-speaking settlers occurred in the ways administrators created individualized and collective racialized meanings of difference between their own race group and Spanish-speaking settlers. King and DaCosta (1996) suggest that the social construction of race has four "faces" which point to its racial formation: doing race, presentation of race, race as social collective, and race as relational and hierarchical. Similar to West and Zimmerman's (1987) "doing gender",

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King and DaCosta suggest that race is something people do and contains a reflexive quality. Doing race requires both introspection and external validation, such that individuals may chose a race within the social parameters and restrictions available. Second, King and DaCosta suggest, in the Goffman tradition, that individuals conduct a presentation of race. Thus, race is also a form of impression management. Third, race is a social collective that is done not only by the self but also among people (groups). It is within these race groups that individuals "draw the colorline and [are] creating boundaries between groups" (King and DaCosta 1996). Finally, King and DaCosta note that race groups are relational and hierarchical. Race groups cannot exist alone but need each other as a point of reference (such as "us" versus "them"). In theory, people view race groups as both mutually exclusive and hierarchical. Over time, racial understandings change to produce more groups (thus, race groups are not exhaustive). The culmination of King and DaCosta's "four faces of race" present an image of race as dynamic and a product of the interplay between the social structure and the actors (both at the individual and group level) and the larger structure. As Berger and Luckmann suggest in The Social Construction of Reality, people are social products who, through social interaction, product a social reality (Berger and Luckmann 1966). Thus, race, as a social construction, is produced through social interaction between people whereby individuals perform race within prescribed group understandings, which in turn reinforces notions of race (group boundaries) and enables the racial formation process. It is within these social interactions that the racialization process occurs and unequal outcomes emerge along race lines.

Migration, Settlement, and Impact

      As new immigrant groups arrive, scholars begin their detailed examination of the new group including how the local community responds. Scrutiny surrounding a group is heightened when a group grows at a rapid pace and job insecurity is high. Authorization status and wage lowering are examples of areas under scrutiny. Research investigating the settlement patterns among immigrants to the United States began with Robert Park and the Chicago School (Park 1967) and continues through to more recent studies of new settlement communities (Bachmeier 2007; Durand, Massey, and Charvet 2000; Durand, Massey, and Zenteno 2001; Suro and Singer 2002; Singer 2004). Just as scholars examine each new immigrant wave in different ways, people within the receiving communities respond in a variety of ways. Some accept the new settlers while others become more firmly entrenched in their xenophobia. Others adopt inconsistent responses, such as being welcoming in particular areas of their lives or parts of town and not others. Following the release of the 2000 Census, researchers noted Mexican immigrants represented the largest foreign-born group in the United States (Bachmeier 2007; Fix, Zimerman, and Passel 2001), and Latinos more broadly configured the largest racial and ethnic minority group (Suro and Singer 2002). Some referenced these demographic changes as the "browning" or "Latinization" of America (Bonilla-Silva 2004; Rodriguez 1998). Researchers also analyzed and commented on the widespread dispersion of Latinos across the country, particularly to new destination cities, noting what many local communities already observed: an increased presence of Latinos in non-traditional destination cities (Gozdziak and Martin 2005; Fischer and Tienda 2006; Light 2006; Singer, Hardwick and Brettell 2008; Zavella 2000; Zuniga and Hernandez-Leon 2005).

Not all Latinos are immigrants; many are longtime residents. Where Latinos and immigration overlap, settlement patterns are shifting. An overall trend noted in immigration studies points to the changing settlement patterns of immigrants from traditional settlement communities, such as Los Angeles, California, to new destination cities, such as Charlotte, North Carolina (Bachmeier 2007; Bender, Clawson, Harlan, and Lopez 2004; Durand, Massey, and Charvet 2000; Elliott 2004; Light 2006; Singer, Hardwick and Brettell 2008; Zavella 2000). Embedded within the literature on new destination cities is research focused on the role of United States economic policies, particularly in connection with Mexico and other "push" and "pull" factors (Durand, Massey and Charvet 2000). The combination of the various push and pull factors, structural imbalances between societies, and social networks led to an increased number of Latinos crossing the border and settling into new communities in the United States.

While many Latinos have settled in new destination cities, this dispersion has occurred, as with previous migration waves, in a distinct pattern. Robert Suro and Audrey Singer (2002) note that "[t]he Hispanic population is growing in most metropolitan areas, but the rate and location of that growth varies widely" (p. 3). Several researchers describe Latino settlement patterns, each discerning anywhere from four to six patterns of settlement, depending on the identified group of investigation. Suro and Singer (2002) suggest the pattern of Latino settlement is distinct within four metropolitan types by Latino population base and by Latino population growth: Small Latino Places, New Latino Destinations, Established Latino Metros, and Fast-Growing Latino Hubs. Small Latino Places, such as Rochester, New York and Cleveland, Ohio, are cities with a relatively small Latino base and experienced minimal Latino growth in the last ten to

twenty years. New Latino Destinations, such as Raleigh, North Carolina and Louisville, Kentucky, are cities, which historically received few Latino residents yet experienced tremendous Latino population growth between 1980 and 2000. Established Latino Metros, such as Los Angeles, California and Chicago, Illinois, are cities that historically attracted strong numbers of Latinos and experienced comparatively little growth between 1980 and 2000. Finally, Fast-Growing Latino Hubs, such as Dallas, Texas and Phoenix, Arizona, are cities with a large Latino population base and continued to experience large Latino population growth. Each of these metropolitan areas experienced a numeric increase in Latinos; however, some of the cities were historically "destination" cities for Latinos while others are emerging as "new settlement communities."

Of the 100 largest metropolitan areas in the United States, Suro and Singer (2002) place fifty-one Metropolitan Statistical Areas (MSAs) within the New Latino Destinations (Table 1). The New Latino Destinations represent thirty-five states in every region in the United States, with Latino population rate increases from 146 percent (Hartford, Connecticut) to 1,180 percent (Raleigh, North Carolina) from 1980 to 2000. The overall average for this metropolitan type was 341 percent, with a median of 225 percent. The most rapid overall Latino population growth occurred in the New Latino Destinations, which dramatically altered the demographic compositions of these metropolitan areas.

Table 1. Latino Settlement by Metropolitan Type

Base		Growth	
		Slower	Faster
Small		Small Latino Places	New Latino Destinations
		Represents 4% of Latino population, experienced 81% Latino population growth between 1980 - 2000 Ex) Rochester, NY; Cleveland, OH; Pittsburgh, PA	Represents 19% of Latino population, experienced 303% Latino population growth between 1980 - 2000 Ex) Raleigh, NC; Louisville, KY; Richmond, VA
Large		Established Latino Metros	Fast-Growing Latino Hubs
		Represents 52% of Latino population, experienced 97% Latino population growth between 1980 - 2000 Ex) Los Angeles, CA; Chicago, IL; Miami, FL	Represents 25% of Latino population, experienced 235% of Latino population growth between 1980 - 2000 Ex) Dallas, TX; Phoenix, AZ; Stockton, CA

(Source: Suro and Singer 2002)

The settlement patterns of Latinos reflect a trend in immigration patterns among all foreign-born residents in the United States: the transition to new settlement communities. While Suro and Singer (2002) note the settlement trends among all Latinos, foreign-born and not, Singer (2004) and Singer, Hardwick and Brettell (2008) examine the settlement trends among all foreign-born residents. Latino immigrants comprise the greatest share of all foreign-born residents in the United States (Bachmeier 2007; Bump, Lowell, and Pettersen 2005). Thus, the settlement trend to new destination cities or new gateways among the foreign-born in the United States concurrently reflects the settlement trends among all Latinos to new settlement communities.

A gateway city, as defined by Lin (1998), is a "subset of world cities, which serve not only as command centers in the cross-border movement of capital and labor but also as a critical nodes in the process flows of commodities and cultural products" (p. 317).

Singer's (2004) and Singer, Hardwick, and Brettell's (2008) typologies reflect three factors in the classification of metropolitan immigrant gateways: size of native and foreign-born population, rate of growth of foreign-born population, and dominance and continuity of foreign-born settlement. Simply stated, gateway cities are those metropolitan areas where large numbers of foreign-born persons settle (Clark and Blue 2004; Gozdziak and Martin 2005; Ley and Murphy 2004; Price and Benton-Short 2007; Singer 2004a; Skop and Menjivar 2001). Gateway cities are not permanent, fixed locations; instead they change over time depending on various social and economic influences (Price and Benton-Short 2007).

Singer (2004) and Singer, Hardwick, and Brettell (2008) identified six immigrant gateway city patterns among immigrants across the United States based on size and growth of immigrants during the 20th century: Former Gateways, Continuous Gateways, Post-World War II Gateways, Emerging Gateways, Re-Emerging Gateways, and Pre-Emerging Gateways. Former Gateways, such as Baltimore, Maryland and Philadelphia, Pennsylvania, represent cities that historically attracted large numbers of immigrants and did not sustain growth. Continuous Gateways, such as New York, New York and Chicago, Illinois, historically attracted immigrants and sustained high volumes over the century. Post-World War II Gateways, such as Los Angeles, California and Miami, Florida, emerged as immigrant destinations following the second half of the 20th century. Emerging Gateways, such as Atlanta, Georgia, and Washington, DC, increased in immigrant population over the last 25 years, with little to no previous immigration base. Re-Emerging Gateways, such as Phoenix, Arizona and Seattle, Washington, historically attracted large immigrant volumes, diminished during the middle of the century, and

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recently re-emerged as immigrant gateways. Finally, Pre-Emerging Gateways, like Raleigh, North Carolina and Salt Lake City, Utah, recently gained large volumes and growth of immigrants and are expected to continue as immigrant destinations. The settlement patterns among Latinos and immigrants represent a similar pattern among more recent immigration settlement trends, in that Latinos represent the largest racial and ethnic group in the United States, and Mexican immigrants represent the largest foreign-born group. Thus, the emerging new settlement cities among Latinos and immigrants more broadly, in part, reflect the general settlement trend of Latinos. For example, many of the Pre-Emerging Gateway cities identified by Singer (2004) and Singer, Hardwick, and Brettell (2008) were identified as New Latino Destinations by Suro and Singer (2002).

Scholars have examined the emergence of new settlement cities for Latinos and gateway cities for immigrants; however, an innovative way to explore the relationship between these two emerging phenomena is through the reactions of health care administrators. This study contributes to understanding the relationship between the exponential growth of a racial/ethnic group and the settlement patterns of all foreign-born residents by examining the confluence of Singer's (2004) and Singer, Hardwick, and Brettell's (2008) "New Immigrant Gateways" and Suro and Singer's (2002) Latino destination cities.

While immigration and demographic theories proposed understandings of settlement, this project examines the impact of settlement on a not-for-profit health care system in a new destination community. Existing immigration and demographic theories are loosely pooled into four categories: spatial theories (e.g., Wright and Ellis 2000),

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social network theories (e.g. Durand and Massey 2004), economic theories (e.g., Borjas 1989; Ong, Bonacich, and Cheng 1994) and explanations for why immigrants choose particular destinations (e.g., Brettell and Hollifield 2008; Durand and Massey 2004; Portes and Rumbaut 1996; Wright and Ellis 2000). While all of these theories are critical to understanding immigrant networks, perceptions of settlement impact are central in this study. This research builds on existing understandings of immigrant social and geographic network theory by providing another perspective to the health care access picture. Granovetter (1992) warned, "behavior is embedded in concrete, ongoing systems of social relations" (p. 6); therefore no analysis of administrators' perceptions is complete without examining the "contexts that enable, constrain, and shape them" (Hallett and Ventresca 2006: 223).

The changing demographics of Seventon provide an ideal setting for investigating the ways organizations approach care in the face of changing community demographics. Hospitals are the most visible and easily recalled site associated with health care, yet they are also the location where the fewest, yet sickest, people visit (Thomas 2003). Hospitals, like schools, are also sites where the needs of immigrants and native-born people intersect. In addition to being vulnerable because they are sick, Spanish-speaking patients, especially those who solely speak Spanish and who newly arrived in the community and/or the United States, represent a particularly vulnerable population in terms of language, insurance knowledge and coverage, source of care, and level of acculturation (Escarce and Kapur 2006). Language represents one of the largest barriers to care for Spanish-speaking patients. Hospitals, and the health care system overall often rely on family members or outsourced telephone translation services to act as a conduit

between medical provider and patients, potentially resulting in medical errors and medical miscommunications. These barriers to care present obstacles for Spanish-speaking immigrants needing health care. Health care organizations grappling with the increased presence of Spanish-speaking immigrants in their communities must confront the existing barriers to care for this particular patient population across the entire care continuum, from both a medical and administrative frame. They must assess how they provide care and analyze the need for additional service opportunities.

WHY SEVENTON?

This study examines how the administrators of a health care system ("St. Peter's Seventon Health System"), embedded in a new destination city ("Seventon"), discuss the impact of newly arrived Spanish-speaking settlers on the health care system (Table 2). St. Peter's Seventon Health System is located in the Atlantic South and represents both a New Latino Destination city (Suro and Singer 2002) and a Pre-Emerging Gateway for immigrants (Singer 2004; Singer, Hardwick, and Brettell 2008). Thus, Seventon is home to two related emerging demographic trends: new development of and quickly growing settlement communities for Latinos and immigrants in the United States.

Table 2. Foreign-Born and Latino Populations in Greater Seventon

	1980		1990		2000		2009	
	N	%	N	%	N	%	N	%
Foreign-Born	17,700	2.3%	22,500	2.6%	45,000	4.5%	74,000	6.2%
Latino	7,000	0.9%	8,800	1.0%	23,200	2.3%	47,000	3.9%
Total	760,000		866,000		1,000,000		1,200,000	

Source: Bureau of U.S. Census 1980, 1990, 2000; American Community Survey 2009

Seventon historically attracted very few foreign-born residents but its foreign-born population grew approximately 150 percent from 1980 to 2000, more than the national average of 121 percent (Capps, Fortuny, Zimmerman, Bullock, and Henderson 2006). Additionally, the Latino population in Seventon increased at a rate of

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approximately 230 percent from 1980 to 2000, far above the national Latino population growth rate of 142 percent. The placement of Seventon as a New Latino Destination and as a Pre-Emerging Gateway for immigrants makes it an ideal location for examining the impact of Spanish-speaking immigrant groups, as both the foreign-born population and Latino population are experiencing tremendous growth without an existing population base. A focused examination of newly emerging destinations provides a more complete picture of the impact of immigration on all cities and how immigration impacts the less traditional and often under-equipped destinations.

While Seventon occupies a new role in contemporary immigration and migration history, it also has a unique history within the United States. Seventon was one of the first permanent English-speaking settlements, a pivotal location for the American Revolution, and most famously, a Confederate stronghold during the Civil War. More recently, Seventon experienced a strong separatist movement during school desegregation, resulting in nearby public schools closing, and widespread controversy when a statue of a famous Black Seventon member was proposed along a promenade of famous White Confederate soldiers. Seventon's history is marked by episodes of high racial tension. Contemporary race relations in Seventon remain contentious, often typifying assumptions of highly segregated Black and White southern communities. On average, Black members of the Seventon community are worse off in every economic indicator than White community members, when considering household income, education level, home ownership, and professional occupations. In addition to its historic and contemporary racial tensions, Seventon embodies a Southern culture. Once represented by a blue-blooded tobacco plantation system, the rigid class structure lingers. Common questions

from a resident of Seventon are, "Who's your mother's family?" or "Where did you go to [high] school?" These questions signal distinction in Seventon, as prominent members have familial names well known in the community. High school references allow for less known members to connect to either the male or female private schools for distinction and serve as an indicator of class status. Seventon, with its deeply entrenched racial and class history, is experiencing a transition in local demographics. These new changes and its unique history make Seventon a compelling city to investigate how new destination cities incorporate new Spanish-speaking settlers.

<center>WHY HEALTH CARE AND ST. PETER'S SEVENTON HEALTH SYSTEM?</center>

Selection of this particular health care system stems from personal connections to the site and the open access granted by a key leader within the system. In addition to the relative convenience offered by this particular research site, health care as an industry is an ideal location to examine immigration. Health services and supplies are a large part of the United States economy and are a site of political and social contestation. Health care represents 15 percent of the 2005 Gross Domestic Product, contributing approximately $1,738 billion in total contributions to the United States economy (American Hospital Association 2007). National health expenditures total $1,860 billion, representing 16 percent of the 2005 gross domestic product, an increase of 76 percent since 1980 (American Hospital Association 2007). While the health service and supply expenditures increase as a proportion of the Gross Domestic Product, consumer out-of-pocket payments are simultaneously increasing, while community hospitals and hospital beds are decreasing (American Hospital Association 2007). In 2006, health care was the largest industry in the United States, accounting for fourteen million jobs (U.S. Department of

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Labor 2008). In addition to representing a significant amount of the economy, health care ranks as a top national concern among American adults. Polls conducted by NBC/Wall Street Journal, CNN/Opinion Research Corporation, USA Today/Gallop, Pew Research Center, and Fortune Magazine all ranked health care as a top problem identified among Americans (CNN 2008).

St. Peter's Seventon Health Care System also has several key features: it is located within a New Latino Destination and Pre-Emerging Gateway city; it is a not-for-profit health care system (rather than single hospital, physician practice, outpatient setting, or part of a for-profit network); it is embedded within a regulatory state; and it is religiously affiliated, specifically Catholic. In 2002, among the top 100 metropolitan statistical areas, not-for-profits represented approximately 73 percent of metropolitan hospitals and 75 percent of suburban hospitals (Andrulis and Duchon 2005). Thirty-six states maintain some type of certificate of need program, law, or agency regulating health care costs and expenditures. The regulatory process includes calculation of charitable care as a part of the "certificate of need" (CON) application process for new services. Catholic hospitals represented 13 percent of all community hospitals and 16 percent of hospitals admissions in the United States (Catholic Health Association 2008). Not-for-profit and Catholic hospitals are often cited as capturing a disproportionate amount of the charitable care, often as a part of their mission to serve disadvantaged groups. It is a common experience to see nuns and priests in administrative meetings, or providing ecclesial or medical care to patients. These religious figures serve the Catholic Church in a variety of ways: as administrators, health care providers, and as religious leaders.

At the time of this study, St. Peter's Seventon Health System captured approximately 32 percent of the in-patient market share in the Seventon area. The other major providers in the planning district are a for-profit system that captured 45 percent of market share, and a teaching hospital that earned 23 percent of market share. St. Peter's Seventon Health System contributed approximately 32 percent of the charitable care while having approximately 28 percent of the staffed beds. Thus, it captured a disproportionate amount of charitable care and in-patient utilization compared to beds, staffing, and other available resources. However, St. Peter's Seventon Health System received significantly fewer Hispanic patients than the other hospitals in Seventon. St. Peter's received 20 percent of Hispanic in-patients compared to 31 percent at the for-profit hospital and 49 percent at the teaching hospital. Nationally, hospitals provide one of every ten jobs in the United States (American Hospital Association 2006). St. Peter's Seventon Health System is the eighth largest private employer and thirteenth largest among private and public employers in Seventon, employing a little over 5,000 people.

St. Peter's Seventon Health System is comprised of four acute care hospitals, approximately 20 physician practices, roughly 35 outpatient centers, 2 retirement communities, a school of nursing and medical imaging, and a family residency and pharmacy residency program located in various areas across the greater Seventon metropolitan area. The four acute care hospitals were the primary focus of this research, although administrators also represented the other entities. For example, I also spoke with the administrator of the physician practices and schools of nursing and medical imaging. The four hospitals included St. Elizabeth's Medical Center, St. George's Medical Center, St. Josephine's Medical Center, and St. Michael's Medical Center (Table 3).

Table 3. Description of St. Peter's Seventon Health System Hospitals

| | St. Peter's Seventon Health System | | | |
	St. Elizabeth's	St. George's	St. Josephine's	St. Michael's
Year Opened	2005	1999	1860	1966
# Staffed Beds	130	230	100	400
Yearly Admissions	9,000	13,500	3,000	22,500
Minutes Downtown	25	20	10	15

St. Elizabeth's Medical Center is the newest hospital within the system, opening in 2005. It is located approximately 25 minutes outside downtown Seventon in a predominately White, middle to upper-middle class community. St. Elizabeth's has approximately 130-staffed beds with nearly 9,000 annual admissions. Its top three service lines are Obstetrics (19%), Orthopedic Surgery (11%), and Gastroenterology (7%). St. George's Medical Center is the second newest hospital, opening in 1999 after beds were transferred from the Seventon city limits. Its campus is located 20 minutes outside downtown Seventon in a predominately White, middle to upper-middle class community experiencing significant growth over the last 10 years from rural to suburban areas. St. George's has approximately 230-staffed beds with nearly 13,500 annual admissions. The top three service lines are Obstetrics (13%), Gastroenterology (7%), and Infectious Diseases (7%). St. Josephine's Medical Center opened 150 years ago in downtown Seventon by Black physicians. It is located ten minutes outside of the city center in a predominately Black, working class to poor downtown community. St. Josephine's has approximately 100-staffed beds with a little over 3,000 annual admissions. The vast majority of the St. Josephine's cases are Psychiatry (60%), with Cardiology (6%) and Pulmonary (6%) as its closest other service lines. Finally, St. Michael's Medical Center is the flagship hospital

of the St. Peter's Seventon System. It is located 15 minutes from the city center in a predominately White, middle to upper-middle class urban community. St. Michael's has approximately 400-staffed beds with nearly 22,500 admissions annually. The top three service lines are Obstetrics (12%), Orthopedic Surgery (8%), and General Surgery (8%). The spread of the system's facilities across the greater Seventon area allows for a comparison within the system, as the demographic trends in the immediate areas surrounding each facility are different, and the offered patient-care services match many of those demographic trends.

One of the more unique characteristics of St. Peter's Seventon Health System is its Mission Department. As a Catholic, not-for-profit health care system, St. Peter's commits itself to providing care to disadvantaged groups through institutionally sponsored initiatives and community partnerships. Free mobile medical units are one such example. The mobile medical units post scheduled stops throughout Seventon, and medical care is available to anyone irrespective of health insurance. In addition to outreach programs, the Mission Department provides spiritual care to patients, visitors and staff in the tradition of the Catholic Church.

Using regional connections from my previous professional experience as a planning analyst in the health care industry, I established connections with administrative leadership and was granted access to conduct my research. My previous experience also afforded me "insider" status, which helped me establish rapport with administrators and provided me with familiarity on medical language and the business development practices of health care. However, there were limits to my insider status. According to Twine (2000), "Insiderness generates its own particular barriers. For example, insiders

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are expected to conform to cultural norms that can restrict them as researchers." Thus, while my knowledge of the health care industry afforded me some level of "insider" status, I was not an employee of the system and participants were often skeptical of my intentions. As Naples (2003) suggests, qualitative researchers are never simply insiders or outsiders. The simple binary of insider/outsider fails to acknowledge the specificity of social locations, the fluidity of relationships and interactions.

My investigation of administrators' and diversity committee members' understandings and attitudes of recent demographic changes occurred through the study of racial discourse, or "the way people talk about race, their racial vocabularies, racial narratives, and their definitions of race" (Twine 2000: 20). I examined this discourse as a culturally collective discourse, rather than trying to infer or assume an individual's motivations. Thus, my analysis focused on the patterns of discourse across administrators rather than assumptions about an individual's prejudices. During an era of colorblindness, when Whites study race relations among other Whites, they often face "the ethical dilemma of inevitably violating that culture because one is making visible that which people struggle and desire to keep invisible" (Twine 2000: 20). Thus, I also violated some of my "insider" status as a White, middle class female by wanting to talk about the emergence of a new race group. The stakes of discussing race are even higher in a community once a stronghold of the Confederacy and still lingering with racial tensions. To talk about race at all in this community risks being perceived as one of the "good ole boys" still stuck in the Confederate past. Therefore, administrators take great personal and professional risk by discussing race relations throughout the interviews, and even greater risk discussing race in executive meetings.

WHY ADMINISTRATORS?

Numerous studies have investigated the relationship between immigration and health care yet the perceptions of health care administrators have been understudied. Administrators are embedded within a larger socio-economic and political environment that recently underwent changes to the local population, including a recent influx of Latinos and immigrants. Thus, the administrators, as members of the larger community, are influenced by those changes. Administrators, while employees of one particular hospital, are also embedded in a larger local health care system, St. Peter's Seventon Health System, and an even larger regional health care system, St. Peter's Health System, which extends beyond the Atlantic south. The regional health care system is influenced by the Catholic Health Association, which serves as the overarching support structure for all Catholic hospitals and health care organizations. The perceptions and subsequent decisions of administrators within a health care system have real material consequences for patients and other staff members. Administrators decide the goals and objectives, including programs offered, staffing levels and qualifications, and service line changes. Thus, if administrators do not recognize the changing demographics and needs of the community, or choose not to adjust services to those changing demographics, particular groups may receive inadequate or differential care as a result. Therefore, the perceptions of administrators substantively and directly impact the quality of patient care.

In addition to directly influencing the type of care users of health care services receive, the perceptions of administrators also influence the type of care and services other employees provide or deem necessary. As administrators set the policy, procedures, staffing levels and staff qualifications, employees respond according to the rules set by

their leadership. For example, if administrators do not require a bilingual intake nurse to be on duty during each shift, a non-English speaking patient may have a much longer patient-wait time until a translator becomes available. Understanding administrators' perceptions can be a conduit for helping to change those perceptions and literally impacting the quality of care patients receive. If the administrative blocks are exposed then the health care system can begin to understand how to make appropriate changes to suit the new settlers' needs.

CHAPTER II

RESEARCH METHODS

This study relies on qualitative research methods to understand how health care administrators in new destination cities perceive Spanish-speaking settlers as impacting their health care system. Qualitative research is interpretive of the social world, a method that tries to make sense of phenomena in terms of members' meanings. Qualitative research assumes the research process is interpretive in nature: researchers' assumptions and perceptions (my subjectivity) influence all aspects of the research process, from topic selection to data analysis. Weber states that sociology is "a science which attempts the interpretive understanding of *social action*" (Weber 1947: 87, emphasis added). According to Weber, the goal of social research is verstehen - explanatory understanding, subjective interpretation, and comprehension – of intentional and social behavior (Weber 1947). As such, this project aims to understand how health care administrators, diversity committee members, and nurse managers frame the institutions' role and response to new settlers in their community.

MY ROLE WITHIN THE HEALTH CARE COMMUNITY

While the data collection for this project initially began in May 2008, my interest in health care began in 2001 when I worked for a health care system. This project stems from my academic and previous professional experiences, combining my academic interests in social inequality, specifically related to United States race relations, and my previous professional experience as a health care planning analyst, where my job required the analysis of health care utilization trends and projections of service needs. As a planning analyst, I served on a community needs assessment group, examining the needs

of local immigrants and the corresponding available medical resources. The results of this assessment suggested an extreme disparity between immigrant needs and local resources. I questioned how health care providers claimed to provide services to all people, yet disproportionately served the middle to upper-middle class White community. Although I believed the unequal treatment stemmed from a business development standpoint where administrators sought the most profitable venture rather than made decisions through an overtly racist lens, I struggled to understand how my fellow employees reconciled those disparities.

These questions heightened when I heard a story similar to Juanita's situation. A friend was placed on hospital bed-rest for approximately one week before she gave birth to her son. During this week, she shared her hospital room with another woman, also on bed-rest. On the surface, the significant difference between the two women was their primary spoken language: my friend spoke English while her "roommate" spoke Spanish. My friend routinely received hospital care and understood all of her medical procedures. Her roommate, on the other hand, had to wait for the one bilingual nurse or for her young son to serve as her translator. When I heard of their disparate experiences, I wondered if the administration knew of this type of situation and if they were aware of the increased presence of Spanish-speaking patients in the community. I also wondered if the language barrier served as a new proxy for race and class tensions but language served as an easier way to ignore the issue. How could the hospital claim to provide care to all but allow situations like this to routinely occur? What blocked the hospital from not proactively responding to this type of situation? These questions formed the basis of my dissertation.

QUALITATIVE METHODOLOGICAL PLAN

The Health System

I began my data collection with an email contact with the Senior Vice President for Planning and Business Development. I described the nature of the study and requested a copy of the organizational chart to identify administrators, a list of nurse managers at each hospital, and a list of the diversity committee members. This office has access to all employee records and serves as the primary source of entry for most external non-medical research studies at the health system. This Senior Vice President informally acts as the "second-in-command" for this particular health system, under the Chief Executive Officer. I conducted in-depth interviews with key administrators and diversity committee members, as well as focus groups with nurse managers at St. Peter's Seventon Health System.

I began all interviews and the focus groups first with a description of the study, and by reviewing and having participants sign the informed consent document. Participants were told, "The purpose of this research study is to understand your perceptions on how this hospital and health care system is impacted by the increase in Spanish-speaking persons in the community over the last ten years. I hope this study will allow me to write my dissertation for the Sociology Department." Once the informed consent form was signed, I turned on my digital recorder and asked respondents to fill out a brief, eight-question demographic questionnaire. The questionnaire asked interviewees to self-identify their job title, role within the system (upper management, lower management, etc.), tenure within the system, years lived in the city, highest level of education, and race. All participants agreed to have the interview recorded.

I conducted in-depth interviews with administrators at St. Peter's Seventon Health System. I selected a random sample of two-thirds of the administrators from the entire pool of health care administrators at St. Peter's Seventon Health System, for a total of 37 potential participants. Six individuals declined interviews resulting in a response rate of 83.8 percent. I conducted four additional administrative interviews based on recommendations during interviews, for a total of 35 interviews. I identified health care administrators by their position in the 2007 St. Peter's Seventon Health System Strategic Plan Executive Organizational Chart. The Senior Vice President notified all administrators of the upcoming study during an Executive Council meeting, which meets twice per month and consists of all members of the executive structure. The Senior Vice President announced that with his support and the health system's Internal Review Board (IRB) approval, I was conducting interviews with administrators during the summer 2008 and would solicit their voluntary participation. I followed-up by email within two weeks of the Executive Council meeting to schedule interviews with selected administrators.

I conducted semi-structured, open-ended interviews to gauge key administrators' perceptions. These administrators occupy a position within the executive management structure of St. Peter's Seventon Health System. Topics discussed included:

- perceptions of organizational program or service-line changes, including modifications to existing service-line or program specific items (e.g., changes to the women's and family services programs or to a specific prenatal class),
- organizational structure changes, including objectives, strategies, perceived solutions, program implementation, regulatory procedure changes, and

effectiveness of delivery of care and services (e.g., changes within the

organizational structure and business development goals, including the certificate

of public need process),

- influence, or perceived influence, on the organization's decision-making

  processes (e.g., assessing the administrator's level of influence on the overall

  system and who they perceive to have decision-making influence),

- and perceptions of barriers to delivery of care or service implementation.

The use of semi-structured interviews permitted the addition of other information to the

interviews, such as institutional or organizational texts. If a respondent referred to a

particular text as a guide in their decision-making process, this text was then brought into

the interview. For example, one interviewee mentioned brochures developed to advertise

the diversity committee within the organization and community. We then referred to the

actual brochure to discuss issues around communication and community awareness.

Throughout all of the interviews, if administrators referred to texts within the system as

guiding their decisions, I requested a copy of these texts.

I asked administrative leaders to participate in a 90 minute, one-on-one, face-to-

face interview. All interviews were semi-structured, but tended toward open-ended,

conversational questions. I encouraged respondents to provide extensive details about

how they perceive Spanish-speaking settlers as impacting their daily work lives, their

hospital, and the entire health system. I asked where they received information on

Spanish-speaking immigrants, how they feel about the changes within their daily work

lives, and the changes within the hospital and the system.

Participants were surprisingly frank during the interviews. While the executive leadership of the health system supported my study by writing a letter of support for my I.R.B. process and by permitting administrators', diversity committee members', and nurse managers' time during the work day to meet with me, I did not perceive much hesitation or caution among participants. Participants often double-checked that interviews were confidential before stating dissatisfaction with a particular program or before telling an unflattering story about the system.

The administrative participants demographically reflected the entire administrative team. They were mostly White (33 White, 2 Black) and evenly split between men and women (18 men and 17 women). Administrators ranged in age from 29 to 68, with a mean age of 50. Their years of experience at St. Peter's Seventon Health System ranged from half a year to 21 years, with a mean of 8 years. The mean length of time in Seventon was 20 years, with a range of half a year to 49 years. Administrators were highly educated and included 1 bachelor's degree, 26 master's degrees, 2 M.D.s, and 5 Ph.D.s. I struggled with the inclusion of administrators' racial identity throughout this project. Ultimately, I did not indicate the race of administrators because the number of administrators of color is too small and racial identification may expose their identities. Ensuring the complete confidentiality to the participants outweighed any potential benefits. Additionally, the small numbers of administrators of color challenge any noticeable differences. In most cases, the patterns of responses were similar for both administrators of color and White administrators. However, I did note racial differences if they emerged along racial lines between both administrators and diversity committee members.

I also conducted interviews with members of the St. Peter's Seventon Health System diversity committee. Two-thirds of the diversity committee members were randomly sampled from the entire list of St. Peter's Seventon Health System diversity committee members. The four individuals who were both administrators and diversity committee members were placed in the administrative pool. Of the entire diversity committee sample, four individuals declined interviews, resulting in a response rate of 64 percent. I conducted one additional administrative/diversity committee interview based on recommendations during interviews, resulting in a total of eight interviews. I believe the lower response rate among diversity committee members resulted from a smaller sample size and personal circumstances, including two members moving and one member not using email, rather than as a result of the project scope.

Individuals typically volunteer to serve on the diversity committee, with some encouragement by supervisors. Members are more racially diverse than the administration and tend to be concerned about diversity issues or social justice. Members of the committee represent multiple departments and job positions and meet twice a month. The committee advocates for initiatives and efforts to support cultural diversity in the health system. Thus, many of the ideas shared by administrative leaders and nurse managers may stem from the work of the diversity committee. Potential interview participants were notified of the study during a Diversity Committee meeting.

I was invited to attend a diversity committee meeting by the Chair during my second week in Seventon. The Chair asked me to attend the meeting to share the goals of my research project and to listen as they discussed a draft of the St. Peter's Seventon

Cultural Diversity Plan. I attended the meeting but did not provide any input on the plan. My attendance likely helped me to secure interviews with committee members as the Chair warmly greeted me and seemed excited to participate in the study. I did not record the meeting but did take copious notes and secured a copy of the draft plan.

The diversity committee participants demographically reflected the entire committee. They were more racially diverse than the administrators but still predominately White (5 White, 2 Black, 1 Hispanic) and comprised mostly of women (6 women and 2 men). Committee members ranged in age from 37 to 71 years, with a mean age of 54. Their years of experience at St. Peter's Seventon Health System ranged from 3 years to 13 years, with a mean of 7 years. The mean length of time in Seventon was 22 years, with a range of 7 years to 37 years. Diversity committee members were less educated than the administrative sample and included 1 associate's degree, 4 bachelor's degree, 2 master's degrees, and 1 Ph.D. I again omitted the race of the diversity committee members in order to protect the participants' identity.

The focus of this study is on administrators and how they discuss the system's role and response to changing demographics in the community. However, the diversity committee members are also important to this study for several reasons. First, their role as diversity committee members permits them to discuss racial and ethnic relations in ways often seen as taboo during an era of colorblindness. Second, members are charged with generating innovative ways to incorporate cultural diversity into the system and therefore may be more aware of initiatives within the system addressing demographic changes. Third, as a group who volunteer for a committee that engages cultural diversity issues, I was interested in their perception of the system's role and response compared to

administrators' perceptions. While diversity committee members openly engage in cultural diversity issues, they lack any authority to make system-wide structural changes. Multiple administrators must approve committee ideas, a process that often takes weeks and even years to complete. This is a problematic function of the system as it fundamentally affects the diversity committee's drive toward new projects and does not reward the committee for their efforts toward institutional change. I did not distinguish between administrators and diversity committee members in my analysis unless meaningful differences existed between the two groups.

Nurse Manager Focus Groups

In addition to semi-structured interviews with the administrators and diversity committee members, I conducted focus groups with the nurse managers at two of the facilities (one focus group at two different hospitals) to gauge their perceptions of the changes in St. Peter's Seventon Health System. Nurse managers represent a different level of administration within the hospital, as they maintain some direct patient contact and supervise other nurses within their specialty field. For example, the intensive care unit nurse manager supervised all intensive care unit nurses while she maintained a direct patient care load. According to Jordan, Lynch, Moutray, O'Hagan, Orr, Peake, and Power (2007), focus groups help to discuss sensitive issues because focus groups draw out local conventions around how to talk about particular issues. The focus groups provided an opportunity to understand the nurses' perceptions of changes in the health system and how the nurses see their work as shaped by the changes within the community. Finally, focus groups with nurse managers provided a different perspective on organizational changes. I secured a list of all nurse managers through the Planning and Business

Development Office and requested voluntary participation through email during my first week in Seventon. The email described the purpose of the study, that the focus group would be recorded, and that participation included lunch. I sent an additional request email and two phone messages for all non-responders. I set a minimum of four participants per focus group, which limited the number of focus groups to two out of the four hospitals, with six participants at one facility and four at the second. Focus groups were held on the hospital's campus in a private meeting room.

Focus group members were asked to participate in a one to two hour focus group with other nurse managers from their hospital. I asked participants to provide extensive detail about how they perceive Spanish-speaking immigrants as impacting their daily work lives and the hospital. I asked them where they receive information on Spanish-speaking settlers, how they feel about the changes within their daily work lives, and the changes within the hospital. Focus groups were also informed of the nature of confidentiality and were asked not to share any information about the focus group.

Qualitative Ethics

Interviewees and focus group participants signed detailed informed-consent forms and I offered all complete confidentiality. I also provided complete confidentiality to the health care system and to the city, as respondents can easily be identified in public documents and internet resources by job title if the system is identified. While respondents were highly unlikely to receive any negative ramifications from this study, confidentiality was extended to all participants, hospitals and the city. Additionally, I gave all participants, locations, towns, and non-participants pseudonyms. As previously mentioned, I struggled with the inclusion of administrators' and diversity committee

members' racial identity throughout this project. Ultimately, I did not indicate the race of respondents because the number of people of color is too small and racial identification may expose their identities. Ensuring the complete confidentiality to the participants outweighed any potential benefits.

Given the entrée provided by the Senior Vice President of Business Development and willingness of the Chief Executive Officer to have the system administrators participate, I conducted all interviews during regular business hours, in the participating administrator's office. If the administrator's office was unavailable (for example, if the administrator would rather meet off campus or worked in a cubicle), interviews were held in a location of the participants' choosing or in my summer office at the health system. The heath system provided me with a large, private office, complete with a desk and additional small round table for interviews. The majority of interviews occurred in the interviewee's office.

Reflective and Analytic Memos

Throughout the research process I generated analytic memos. I kept a file for each respondent, including their informed consent, demographic questionnaire, my notes during the interview, and a memo following each interview. These memos described the setting, the course of the interview, and my reflection on each interview. Reflections often included key phrases or "in vivo" codes said during the interviews as potential sources during the coding and analysis process. I also jotted down reflective notes as I read back through the transcript files, recalling any other thoughts or memories related to the interview.

Memos were also kept throughout the coding process, describing emerging codes and how codes may relate to one another. These analytic memos generated the substantive chapter themes as codes emerged from the data and became categories of analysis. I used the analytic memos to think across the data and connect codes to categories and categories to theory. For example, during one administrative interview, Beth Schorte, an upper management administrator, described changes she noticed around Seventon and elsewhere, "We're just, there's no boundaries anymore. I mean, people are just everywhere." Following this interview I noted her animated gestures during this portion of the conversation. Beth was very excited, gesticulating broadly and the pitch of her voice rose. I coded this section of her interview as "no boundaries" and made additional memo notes about how boundaries may fit with other emerged codes. I made similar codes across interviews and the coding "no boundaries" established the basis for Chapter IV, "All Patients are the Same, Until They Become Neighbors."

Coding and Analysis

Interviews and the focus groups were transcribed verbatim, including notations of pauses, "uhmms", "ahs", and other misspeaks. Following the transcription, I reviewed each interview for accuracy and to remind me of each interview. If while reading over the transcript, potential codes or key phrases emerged, I wrote those down in the individual's memo record. Following the initial review, I coded each interview using line-by-line coding, which allowed for codes to emerge directly from the data (Charmaz 2006; Emerson, Fretz, and Shaw 1995; Rubin and Rubin 2005). I had some a priori ideas of potential codes. However, the open coding process, while tedious and time consuming, allowed for codes to emerge from the data and opened the data to codes not previously

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considered. Following this open coding process, all open codes were sorted into themes. For example, Beth Schorte's comment above was initially coded "no boundaries." I sorted all codes related to "boundaries" into one tree file or theme file and analyzed across that information to summarize the material in analytic memo, what Weiss refers to as "local integration" (Weiss 1994). Once I established a theme, I re-coded the data within that theme to establish connections across interviews and patterns across codes. This focused coding process, "involves building up and elaborating analytically interesting themes, both by connecting data that initially may not have appeared to go together and by delineating sub-themes and subtopics that distinguish differences and variations within the broader topic" (Emerson, Fretz, and Shaw 1995). In the example above, I shifted the tree code "boundaries" to "group boundaries" to include references to both the interviewee's race group and their identification of other race groups' boundaries, noting geographies of difference and openness. Throughout the analysis process, the idea of "group boundaries" became an integral code in explicating the process of the "color-line" as part of racialization and part of racial formation. Thus, the initial code of "no boundaries" became one portion of a larger pattern discussing the color-line, which included "no boundaries", as well as "changing demographics," and "shifting resources." Finally, after the coding process I used the analytic memos to connect the codes to the theory.

STUDY LIMITATIONS

No study is without limitations, and this is no exception. A significant limitation is the homogeneity of participants, especially in a racially diverse community. While the participants demographically represent the administration of St. Peter's Seventon Health

System, they are predominantly White. The numbers of people of color are far too small to discuss any potential differences in responses among administrators of color and White administrators. Thus, my study focuses on the response of one particular population, Whites, within a multiracial community. A future study would benefit from casting the research "net" wider and incorporating the response from various populations within Seventon. This study could have benefitted from examining the perspective of the Spanish-speaking community, particularly among patients who have utilized St. Peter's Seventon Health System. A future study should consider examining the mix of responses and reactions throughout the Seventon community, including insights from various constituents throughout the community, other health care systems, and other sites of integration (like schools).

This project is also limited methodologically by only gathering qualitative data. Quantitative data on utilization rates among Spanish-speaking patients across the care continuum would have greatly improved the depth of analysis and provided rich information to use during in-depth interview with administrators. For example, when administrators suggest that St. Peter's Seventon was far from the "tipping point" for developing programs and expanding care delivery to include Spanish-speaking patients, actual utilization rates could have proved instrumental in challenging utilization rates and for asking when the system might reach the "tipping point."

Finally, this project provides insights into the dynamics of one health care system in one community, located in one region of the United States. New destination cities are located throughout the United States and with different race relations histories. While Seventon is known for its role in the Confederate south and for its enduring race

problems, other new destination cities provide different historical contexts to examine this growing phenomenon. The comparison of new destination cities in different regions, with different histories would provide a deeper, fuller picture of how transition is happening and how the health care community reacts.

I capture a snapshot into the views of administrators of one health care system in one new destination city. While much can be gained from this study, more work is needed to round out the story of how Spanish-speaking settlers are incorporated into their new communities. My hope is that this study will encourage additional research into new destinations and into how health care, specifically, can be a location for social change. If the barriers to care for health care can erode and if the mission to provide care to all can be realized then perhaps the lines that divide us can also begin to fade.

CHAPTER III

"I DON'T CARE IF SHE'S YELLOW WITH GREEN DOTS": FRAMES

OF RACIAL COLORBLINDNESS

When do we talk as though race matters? Health care administrators, like much of the U.S. population, struggle to know when to talk as though race is meaningful and moreover, how to talk about race. Part of the paradox of when race matters stems from the ideological dominance of racial colorblindness. This ideology pushes people to "not see race," or at least, to not acknowledge when they do see race. Not seeing race encourages people to dismiss the ways race is embedded in larger structure arrangements. It blinds people to their own lingering stereotypes and racial attitudes. In this chapter I explore how health care administrators use colorblindness, often as a flexible ideology, to avoid discussing race. This flexible ideology is part of a collective cultural discourse on race and does not necessarily reflect administrators' personal prejudices or biases. Administrators rely on three frames to maintain their racial colorblindness: innocence, minimizations, and universalisms. Additionally, I examine how color-blind racism as an ideology maintains white privilege.

I asked the predominantly White administration of St. Peter's Seventon Health System questions about how the system was adjusting to the new and rapidly growing Hispanic population. While Hispanic immigrants and Latinos migrate to new locations across the country – like Seventon – the health care organizations embedded in those communities must learn how to adjust to the changing demographics. Many patterns of incorporation and reactions among existing residents in new destination communities are

similar to reactions to previous waves of immigrants at the turn of the century, including reception patterns to White ethnics. What is different between the contemporary reception to new groups of people and former waves is the shift to a sanitized way of discussing race relations. Traditional prejudice was defined in ethnocentric terms, typified by general out-group hostility, feelings of threat toward out-group members, and a moral judgment assigned to out-groups (Adorno, Frenkel-Brunswik, and Levinson 1950). More contemporary prejudice is usually masked under the auspices of colorblindness or race neutrality (Bonilla-Silva 1997, 2003; Bonilla-Silva and Forman 2000). As with reactions by others to the waves of new Spanish-speaking residents, administrators and diversity committee members often respond to the changes in Seventon and St. Peter's Seventon Health System in highly racialized terms (Stephan, Ybarra, and Bachman 1999). Yet many of the administrators implement the sanitized talk of racial colorblindness to ensure protection of their identity as tolerant while still espousing prejudiced statements, either knowingly or unknowingly (Bonilla-Silva and Forman 2000). The use of sanitized race-talk was not always consistent. Often administrators regarded the Spanish-speaking population in highly stereotypical terms despite the dominant ideology of colorblindness in the post-Civil Rights era.

IDEOLOGIES AND DISCOURSE

Ideologies provide a framework for viewing the world or supporting a particular worldview. In the Marxian approach, ideologies link to material forces didactically, such that "material forces would be inconceivable historically without form and ideologies would be individual fancies without material forces" (Gramsci 1987: 377). In this sense, racial ideologies are individuals' prejudice without linking to real material disadvantages

for people of color. Ideological discourse serves to obfuscate social reality and benefit the dominant racial group, Whites, with material advantage. According to Heywood (2007), "whether consciously or unconsciously, everyone subscribes to a set of political beliefs and values that guide their behavior and influence their conduct" (p. 3). Thus everyone adheres to some ideology, which in turn influences attitudes and behaviors.

Colorblind racism is an ideology deeply embedded in the social structure and influences people's attitudes and behaviors. The ideology of colorblind racism is not a personality disorder or even an individual shortcoming. Rather, it is the dominant worldview for contemporary race relations in the United States. It is an ideology that many of us perpetuate unknowingly. Consequently, it is neither surprising nor deviant that administrators employ it. Further, administrators' use of racial colorblindness signals the collective cultural discourse on race relations and not necessarily individual's preferences or motivations. Since the ideology of racial colorblindness is anchored within the social structure, the patterns of discursive practices across individuals are more important than individual accounts.

Hollander and Gordon (2006) contend, "talk matters in the production and reproduction of social structure" (p. 185). The collective discursive practices of health care administrators and diversity committee members indicate the embeddedness of the colorblind ideology. Administrators reinforce the macro-level meanings of race and the ideology of racial colorblindness through talk, intentionally or unintentionally. However, ideologies are not static. Foss contends, "to maintain a position of dominance, a hegemonic ideology must be renewed, reinforced, and defended continually through the use of rhetorical strategies and practices" (2009: 210). While the ideology of racial

colorblindness works to maintain White racial superiority through material advantage, not all Whites collectively support White supremacy. Whites, as a race group, occupy different social locations, including class, gender, and sexuality, and are affected by dominant ideologies differently. Individuals have agency and may or may not adopt hegemonic ideologies. While some Whites eschew colorblindness, all Whites benefit from white privilege. However, racial colorblindness is the dominant ideology and likely influences the racial discourse of participants, both consciously and unconsciously. The era of racial colorblindness placed most administrators in a catch-22 where to notice race and thus discuss race risks being deemed a racist yet to ignore race ensures the status quo. It is within this lens that I examine the collective contemporary discursive practices of administrators and diversity committee members for salient features of the ideology of racial colorblindness.

COLORBLINDNESS AS A RACIAL IDEOLOGY

Colorblindness emerged in the post-Civil Rights era in the United States as an ideological backlash to the reforms of the Great Society. The post-Civil Rights era required a re-articulation or transformation of the American racial ideology away from Jim Crow segregation and overt racist discourse. While Jim Crow racism was marked by the explicit goal of white supremacy, the post-Civil Rights era discourse is explicitly de-racialized and seemingly race-neutral. The shift in racial discourse followed socio-political shifts away from the New Deal/Great Society welfare state to stronger notions of individualism and meritocracy. The social welfare policies ushered in by the New Deal were deemed incompatible with the more recent economic and political changes to the American landscape, namely individual rights over group rights. According to Omi and

Winant (1994), the economic stagnation of the 1970s called into question many of the

safety net policies established in better economic times, particularly those programs

which "promised the elimination of poverty and the invidious effects of racial

discrimination" (p. 116). During this same period the political right appropriated Martin

Luther King, Jr.'s famous "I Have a Dream" speech to further their political agenda.

King's expression, "I have a dream that my four children will one day live in a nation

where they will not be judged by the color of their skin but by the content of their

character" (King and Washington 1991: 219) is often used to oppose race-target

programs as antithetical to the Civil Rights Movement. Additionally, proponents of race-

targeted programs are often cited as the "real culprits" in perpetuating racism, people

relegated to historical ways of thinking about race. The effect of addressing the issue this

way is that any group-based attempts are reduced and race is subtly codified into social

structure and political ideology.

While the political right, particularly neo-conservatives, ushered in colorblindness

as an ideology for sweeping social reforms, the right is far from its only proponent.

Moderates, liberals and left-wing radicals often succumb to its promotion (Bonilla-Silva

2003; Wise 2010). For example, President Obama, after indicating how the legacy of

historical discrimination continues to affect people of color, quickly turned to a color-

blind solution:

> Ultimately, though, the most important tool to close the gap between minority and
> white workers may have little to do with race at all. These days what ails
> working-class and middle-class blacks and Latinos is not fundamentally different
> from what ails their white counterparts: downsizing, outsourcing, wage
> stagnation, the dismantling of employer-based health care and pension plans, and
> schools that fail to teach young people the skills they need to compete in a global
> economy…. And what would help minority workers are the same things that
> would help white workers (Obama 2008: 291).

While President Obama and numerous others suggest social inequalities affect all people equally, objective indicators present a very different social reality for people of color. As a consequence, the dominant ideology of racial colorblindness frames social inequalities as private and personal troubles rather than the result of systemic structural arrangements. By rearticulating social programs aimed at eliminating racial discrimination, colorblindness also ignores the historic legacy of discrimination and structural arrangements that continue to benefit Whites. For example, FHA loans that subsidized White flight out of the city and into homogenously White suburbs with racially restrictive covenants enabled Whites to accumulate wealth through home ownership. This wealth potentially affords the children and grandchildren of those FHA subsidized homeowners a college education, a down payment for their own homes, or family inheritances (Lipsitz 2006). Colorblindness, according to Bonilla-Silva, is a "formidable political tool for the maintenance of racial order" (2003: 3). Colorblindness, as a racial ideology, is not simply an attitude; it is anchored in maintaining existing structural arrangements. As an ideology linked to the social structure and existing structural arrangements, the ideology of racial colorblindness serves the interests, material or otherwise, consciously or not, of the White majority.

Over 50 years ago, Herbert Blumer suggested problems in race relations stemmed from a sense of group position (Blumer 1958). Blumer's (1958) group threat paradigm dramatically shifted the focus of racial prejudice away from individual explanations as merely attitudes, personality explanations, such as authoritarian personality, or products of social experiences to "the collective process by which a racial group comes to define and redefine another racial group" (p. 3) and racial hierarchical ordering. Race relations

are collective and emerge when one group defines itself ("us") in opposition to another group ("them").

Colorblind racism, advanced by Bonilla-Silva, proposes racism is "the ideological structure of a social system that crystallizes racial notions and stereotypes. Racism provides the rationalizations for social, political, and economic interactions between races" (Bonilla-Silva 1997: 474). According to Bonilla-Silva (1997) racism persists in sanitized talk so individuals can make prejudiced statements without seeming racist by preceding statements with claims of colorblindness, such as "I'm not a racist but…" (p. 472). Additionally, Bonilla-Silva states colorblind racism operates through frames: abstract liberalism, naturalization, cultural racism, and minimization of racism. According to Bonilla-Silva (2001), frames are the most important aspect of interpretive repertoires and are "central to the maintenance (or challenge) of a racial order… [and] once they emerge they mold or circumscribe actors' views on race-related matters" (p. 67). As such, frames help guide people's understandings and processing of information. These frames are made known through the discursive practices, which in turn, support ideologies. Frames serve as the visible or audible building blocks of an ideology.

FRAMES OF COLORBLINDNESS

Blumer and Bonilla-Silva's theoretical understandings of racial attitudes assist in understanding the perceptions of the administrators and diversity committee members within St. Peter's Seventon Health System. Most participants relied on the ideology of racial colorblindness at some point during our interview. Health care administrators relied on certain frames of colorblindness more often than diversity committee members. Colorblindness was most often framed through projections of innocence ("my Black

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friend told me"), minimizations ("race doesn't matter"), and universalisms ("a patient is a patient"). Often participants crossed frames, such as with racial euphemisms ("dangerous people" or "yellow with green dots"). Universalism, racial euphemisms, and minimization served as racial maneuvers to shift conversations away from racial awareness and explicit discussions of race. Administrators used projections of innocence both as a means to avoid discussing race and as a "sanitized" way to discuss race.

Colorblindness through Innocence

Health care administrators most commonly used the frame of innocence. Innocence emerged in four patterns: outside the job description, personal racial progress, naiveté, and denial.

"I'm not in charge of those areas": Beyond the Job Description as Frame of Innocence. The most common expression of innocence emerged as participants eschewed responsibility or knowledge of changing demographics as outside the purview of their job description. Not surprisingly, due to a lack of explicit inclusion of "diversity initiatives" in their job descriptions, administrators utilized this frame more than diversity committee members. For example, Colton Parson is a middle management administrator in charge of software changes and computer support for various departments across St. Peter's Seventon Health System, including the Emergency Departments (ED). Part of Colton's expressed responsibility is to streamline the discharge process, including discharge instructions. When I asked if those discharge instructions were available in Spanish in the ED, Colton replied, "I have a feeling that's available in Spanish, but I'm not in charge of those areas, so I'm not sure." Colton is the IT support manager and mentioned he is currently in "support mode" for the ED, yet when it came to discussing seemingly

culturally responsive items, he is unsure of what is and is not available in Spanish.

Moments later, Colton suggested that if a nurse needed something in Spanish and it

wasn't available, then

> it would escalate to us, every time… but because we were able to be proactive to meet with customers and understand that… that's… would be one of their needs, then we were able to make sure they had it.

Seemingly culturally responsive items were beyond Colton's job description but he

maintained his professionalism by reassuring that his team was able to proactively

provide for nurses. One consequence of racial colorblindness for administrators is they

abjure responsibility for anything potentially seen as race related such that equitable

treatment for patients is structurally ignored by this ideological restriction.

Will Peppercorn, an upper management administrator at St. George's Medical

Center, similarly deflected responsibility when asked how he might determine barriers to

care for particular patient populations,

> I can't say as an administrator of this facility that I've been engaged in that kind of work. We have a Mission Department, there's a cultural diversity committee and we have Kathleen Vess – I don't know if you've spent time with her – she does a lot of those initiatives for the system.

While Will, as the Chief Operating Officer, works on "all the interconnected parts"

throughout St. George's, he deflects responsibility for questions related to culture, race,

or diversity to the Mission Department of St. Peter's Seventon Health System. A

common theme across all job-related innocence frames was that it was the responsibility

of the Mission Department to know *that* information, particularly related to Spanish-

Speaking patients.

The deflection by both Colton and Will may seem reasonable, even normal,

except for the pattern of this deflection occurring when discussing the needs of people of

color or perceived people of color but not other patients (for example, bariatric patients) that would fall outside of these administrators' job descriptions. In this way, the frame of innocence through one's job served as a way to shift the conversation away from the perceived topic of race and toward anything but race. Deflection because it is not part of the job responsibility is particularly interesting since several members of the administration discussed the importance of St. Peter's Seventon Health System as a matrix organization. Matrix organizations share resources or people across departments. Reporting structures within matrix organizations are often both horizontal and vertical. The nature of a matrix structure also helps information flow among departments rather than become stuck in individual department silos. For example, as a health care provider, employees through St. Peter's Seventon Health System are expected to know information related to bariatric surgery even if they are not bariatric surgeons or nurses. As a matrix organization, administrators are familiar with information outside their job description and immediate control because it is an organization expectation. But when it comes to race, many deflect race as "not part of the job description." The ideology of racial colorblindness, which suggests that race should not matter, places administrators in a difficult situation. If they notice race and readily respond to the needs of patients of color differently then this could potentially be seen as prejudicial treatment. However, knowing how to respond to other patient subsets is appropriate.

"I'm not political, so I don't get into it": Denial as Frame of Innocence. The second most common frame of innocence at St. Peter's Seventon involved denial. This frame was used exclusively by administrators and served either to ignore changing demographics throughout Seventon or to avoid discussing the racial composition of their

neighborhoods. For example, I asked participants to discuss whether they noticed any demographic changes in Seventon over the last 10 years. Most had noticed changes, from changes in the racial composition to expansion of the outlying city westward. The frame of denial was often used in response to questions about how the changes in racial demographics affected their neighborhood, children's schools, or areas they frequented. When asked if he had noticed changes around Seventon over the last 20 years, Aiden Drapper, an upper management administrator at St. Michael's Medical Center, said, "I live in Rockland (a neighboring county) on a farm, so I'm kind of isolated out there." Aiden located himself outside racial changes around Seventon and projected his innocence by referencing his more rural county. Several administrators echoed Aiden's statement, often by referencing where they lived or by expressing how their job kept them out of touch with changes in the community. This is unlikely, given that the community they are out of touch with is the one they have been charged to serve and that even the most rural surrounding counties are experiencing growth in Spanish-speaking residents, particularly for the poultry plants and tobacco farms. The dominance of colorblindness prevents some administrators from even discussing that they see demographic changes. Consequently, administrators do not know how to respond to those changes.

In addition to quick denials, some administrators shifted to the frame of innocence after raising overtly racial issues. Beth Schorte did so, using a similar frame of innocence through denial as Aiden. Beth is an upper management administrator at St. Michael's Medical Center. After she began discussing how she perceived the newly elected Black mayor of Seventon as creating divisions between Blacks and Whites in the city, she said,

When I see him on TV, I just turn him off… because I think he's promoting that, and… I don't know what his agenda is… and I'm not political at all, so I don't get into it, but, um, I think some of that is,… I guess…. I don't have a good sense of that.

While Beth began to express her dissatisfaction with the mayor, she stopped midway and seemingly denied her own opinion about a situation she perceived as problematic. Both Aiden and Beth seemed to bury their heads in the sand when it came to discussing race issues in Seventon. Beth, in particular, shifted her discussion toward innocence, maintaining the illusion of colorblindness. Charles Lawrence suggests, "the primary mechanism by which 'color-blindness' sustains itself is denial" (1995: 3). This denial includes ignoring the everyday acts of institutional and personal racism witnessed every day to the avoidance of talking about race and racism. Consequently, this denial obscures the administrators' realities so they may not even see how it influences their behavior and response to the changing demographics. It is the dominance of the ideology of racial colorblindness which prevents administrators from seeing demographic changes and responding to those changes.

"I actually learned that!": Personal racial progress as frame of innocence. White administrators and diversity committee members often recounted the personal progress they made with regards to race relations. Not surprisingly, diversity committee members were more likely to use this frame of innocence than all other innocence frames, over job description, denial, and naivety. It is likely that diversity committee members, through their self-selection on the committee, saw themselves as either more racially progressive or experienced some transformation in their racial attitudes as a result of serving on the committee. Personal racial progress frames ranged from stories about racist grandparents or parents to the racial diversity of participants' children's friend groups to stories of how

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misinformed they were growing up. For example, when asked about the changing

demographics in Seventon, Joan Nelson, a lower management administrator at St.

Michael's Medical Center, said,

> I remember years ago, that my Dad, he's gone to God, thank God, he said, 'There are more Black people in Seventon than there are White people!' And I'm sure the Caucasian population now is less than the Hispanic and African American people… to be honest with you, I haven't given it a lot of thought. I don't think so much about it and even when I was teaching at boarding schools, this was in the early 60's, I was teaching there and we had integration… I never gave it any thought.

Joan dismissed her own thoughts regarding the changing demographics in Seventon by

framing it through her father's concerns. While she thought there might be more

Hispanics and Blacks than Whites in Seventon, it is not something she would have

considered until she remembered her father's concerns. Even during integration, she

claims race was not something she considered as important. Joan's discussion of her

father's concerns helped to frame her as innocent and someone who doesn't think about

race, even when Whites might be numerically the minority. Joan, knowingly or

unknowingly, reinforces the ideology of racial colorblindness through her discussion of

racial progress. While Joan's father noticed race, Joan progressed beyond thinking of

race.

Other participants recalled the racial progress of their children, describing the

diversity of their children's friends relative to their childhood friends. When asked if her

family had discussed the changing demographics in Seventon, Barbara Sanders, a middle

management administrator for all of St. Peter's Health System, instead discussed her

son's friends,

> It's very interesting. When I look at his circle of friends from high school, um…, when I look at his friends, his circle of friends, he had African American friends,

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> Asian friend, his girlfriend… they have broken up… was a Korean orphan
> adopted by a Japanese father and Jewish American mother. Asian, African
> American students, gay students, straight students. He has a very diverse group of
> friends.

Barbara's discussion of her son's friends showed her as someone who raised a racially progressive son. Yet, Barbara avoided discussing if her family talked about demographic changes by recalling the progressive choices her son made. Since Barbara's son had friends of color, and he even dated a person of color, then she too was free of racial prejudice.

Leah Reaves, a diversity committee member and middle management administrator for all of St. Peter's Seventon Health System, described perhaps the most telling story of personal racial progress when she recalls what she learned about Africans in her 3rd grade elementary history class,

> And you'd learn what their mother did all day, you know, she mashed the corn
> and the father went hunting or whatever. And we were talking about the Congo.
> The little boy's name was Bunga. It was, you know, that Bunga's mother did this
> all day and father did that all day. And, we learned that in the jungle… where
> Bunga and his people live there… there were red monkeys and black monkeys
> and they got into a war. The red monkeys set the jungle on fire and Bunga and his
> people dug big pits and they got down in these pits. And… as the fire swept
> across the jungle floor… it singed the top of their heads… and that's why
> Negroids have kinky hair…. I really learned that in school!

Leah recalled this story to reference how she was raised and how far she had come since that elementary lesson. Later, Leah suggested the image of Bunga remained with her and was something she recently joked about with an old elementary school friend. Leah consistently referred to herself as "liberal" and as an activist for civil rights. She discussed how her family made fun of her when she used her allowance to buy a "colored doll." Yet, in her descriptions of both Bunga and her "colored doll," Leah provided antiquated terms to reference groups of color (e.g., "Negroids" and "colored"). While the

frame of innocence through personal racial progress serves as a rhetorical tool to explain

any lingering prejudices, it also adheres to the ideology of colorblindness by absolving

the speaker of racial prejudices because they, or their family members, are less racist than

in previous generations. Whenever race entered the conversation for administrators, they

quickly maneuvered away from race to highlight their own innocence. This quick shift in

discourse is likely a well-intended move by administrators to ensure protection of their

identity as "anything but racist." These shifts also abide by the norms of racial

colorblindness. However, these semantic moves also deflect engagement in demographic

changes and subsequent distribution of resources to growing communities.

"This came from a very close Black friend": Naivety as frame of innocence. The

last frame of innocence emerged to describe participants' surprise by situations others

characterized as racial. Administrators and diversity committee members used this frame

equally but only women used it. Allison Young, an upper management administrator at

St. Elizabeth's Medical Center, described a Hispanic area visited by the mobile medical

unit,

> For what it's worth, many Hispanics live there…. I've walked there. I've parked
> my car in one parking lot and I could see the building I was going to. … I had my
> purse and I was walking and a policeman drove by and he said, 'Never walk by
> yourself! You will not get to your destination with your purse!' So, he got out of
> his car and he walked me to the new location… But, if you were just a normal
> Caucasian woman walking through… you would think it's a nice place!

Allison was shocked by prospects that she might not make it to her destination, purse in

hand. While her story began as an almost colorblind narrative about the mobile medical

unit, except she inserted it was a Hispanic area, it later served to frame her innocence in

thinking about race relations. Allison never considered that a low-income area needing a

free mobile medical unit might not be a place to openly display her purse. Her

maintenance of colorblindness eroded as she juxtaposed "normal Caucasian women" to

the Hispanic residents of the apartment complex. Allison projected her innocence through

the story of the purse. Her concerns were not focused on the apartment complex primarily

being a place for low-income families but were explicitly a racialized concern of the

Hispanics that live there versus her as the "normal Caucasian." The frame of innocence

through naivety functions to maintain the illusion of racial colorblindness and to

neutralize any missteps taken by the speaker. Racial colorblindness serves as an

ideological block for administrators where they express their own naivety about race

relations and sanitize any race related talk.

In discussing different patient populations of each of the hospitals, Ellen

Procoppio, an upper management administrator for all of St. Peter's Health System, said,

> For St. Josephine's… now there's an ethnic thing… the people in that area some
> of them will go to St. Josephine's. But I have heard from a friend of mine, who
> happens to be Black… say, 'Ellen, that place will never do well because it's a
> Black hospital… and people perceive it as a Black hospital and they don't think
> they'd get the same amount of care as if they went to St. Michael's.' So, if you
> look at the zip code for St. Michael's, you're going to find quite a few people
> down there … they don't think they'd get the same standard care at St.
> Josephine's as they would as St. Michael's and this came from a very close Black
> friend who told me that, I would have never thought of that.

Similar to Allison, Ellen framed her discussion as naivety to the issue but informed by an

outsider, her "very close Black friend." The different perception of the two hospitals was

not something she would have considered – even as an upper management administrator

– unless her Black friend had told her. Both Allison and Ellen maintained the

presentation of racial colorblindness by subtly discussing race through a frame of naïve

innocence; someone else, and usually an authority, the Black friend or police officer,

needed to tell them about the racialized world because otherwise they might not know.

The ideology of racial colorblindness prevents Allison and Ellen from discussing race directly but allows indirect discussion of race and the simultaneous projection of innocence by discussing the views of someone else, like the police officer or Black friend.

Colorblindness through Minimization

Minimization was the second most common frame participants used to avoid discussions of race. Minimizations quickly dismissed and ended questions about Spanish-speaking patients, such as questions about whether they had noticed an increased presence of Spanish-speaking patients. Aiden Drapper, a prominent thoracic surgeon and upper management administrator in St. Michael's Medical Center, stated, "I don't really hear… nor would I have reason to segment Spanish-speaking people for any reason that I can think of right now." Since thoracic surgeons operate on organs in the chest, including the lungs, heart, and esophagus, it is likely a patient's race is important information for the physician. While not assuming Aiden provided biased treatment to his patients according to race, it is likely he considered a patient's race, particularly as incidents of disease and illness often correlate with race (Allison et al 2008). Even for physicians, the stakes of race relations are too high and the restrictions of colorblindness too strong to discuss how race might matter, despite racial disparities in disease and treatment. Aiden's minimization was thus more likely a frame of innocence because the stakes of discussing race in an era of racial colorblindness are too high rather than an unimportant piece of demographic information.

Similarly, when I asked Jack Bear how St. Peter's decided to have a Liaison for Hispanic Health, he replied,

> I think another challenge for us is how do we get beyond that type of labeling to care that is more personal and more customized, and that should be true for every patient, not just Hispanic patients, we should seek to do that.

Jack is an upper management administrator for all of St. Peter's Health System. While under his leadership, Jack's office created the Liaison position. He framed his response to quickly evade discussing race-targeted programs and move beyond them (minimization) toward universal care delivery (universalisms). While St. Peter's Health System has a Liaison for Hispanic Health, Jack stresses a less race-conscious delivery of care. For Aiden and Jack, a patient's race was described as a seemingly insignificant part of their daily patient routine or decision-making process and something which should be avoided. This type of minimization occurred most frequently to quickly convey that race does not or should not matter.

More dramatically, Ralph Allan, a middle management administrator at St. Michael's Health System, discussed how the diversity committee just celebrated Black History Month. In reaction, he asked the diversity committee when Norwegian History Month would be held.

> They've got it. They've got it that you can focus too much on everybody else. Come on, we want balance. We want balance. This isn't Al Sharpton!

Ralph minimized the historical legacy of racism, particularly in Seventon, through his call for Norwegian History Month. This minimization frame suggested race was irrelevant and what was actually needed was balance, not the selective celebration of one group. His association of celebrating Black History Month with Al Sharpton, a controversial minister and activist in the Black community, implicitly suggested the diversity committee was making race relations worse. Ralph's statement nears a universalism frame except he is not suggesting everyone is the same or has the same

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needs. His emphasis on balance suggests one group is getting too much (Blacks with Black History Month) and is causing racial divisions. Ralph likely did not want to begin Norwegian History Month but his comments adhere to the ideology of racial colorblindness by minimizing the importance of Black History Month and the importance of race in social relations.

The frame of minimization avoided discussing race altogether and supports the ideology of racial colorblindness; if you can't see race then it must not matter. Perhaps as an unintended consequence, the frame of minimization also serves to deny the importance of race as a fundamental social division and consequently impacts quality of patient care for patients of color. The frame was implemented during discussions of patient care, hiring practices, the importance of race, operations, and diversity committee events.

Colorblindness through Universalisms

The third frame of colorblindness often used by participants was universalisms. Universalisms were used to refer to both their and the institution's liberal position toward patient care or social networks. Universalisms are similar to Bonilla-Silva's (2003) frame of abstract liberalism, where people invoke ideas of "equal opportunity" and focus on individuals rather than groups (p. 28). At St. Peter's Seventon Health System, often the ideology was invoked to describe indifference to a patient's race for the quality of patient care, such as "what's good for everyone." In these instances, the speaker likely wanted to convey that they were anything but racist and had universal standards for patient care because to notice race risks being perceived as a racist. The most common expression of a universalism was a version "a patient is a patient" ("Jesus is Jesus," "People are all the

same," "People are people"). The frame of universalism was also expressed in more subtle ways. For example, in response to direct questions about how the health system responded to the increased presence of Spanish-speaking patients, Andy Darling responded, "We focus more on remaining broad… focused… and trying to be respectful of cultures through cultural competency versus targeted business lines…. So, I don't understand how I got a Hispanic business line or Hispanic services." Andy is an upper management administrator for all of St. Peter's Seventon Health System. Andy's ideas linked to broader notions of abstract liberalism, where what is good for the group is good for everyone. He expressed that St. Peter's Seventon Health System was focused broadly on services for everyone, not particular race groups. Yet he was perplexed by how St. Peter's developed a Hispanic service line, which was actually a liaison position and not a full service line. Similarly, Nash Finnagan, an upper management administrator for all of St. Peter's Seventon Health System, said, "St. Peter's doesn't really have a thoughtful strategy … relating only to the Hispanics but relating to everyone." For both Nash and Andy, the needs of the broader community served the needs of a particular group. The use of colorblindness also ignored potential cultural needs often associated with particular race groups. Here, colorblindness also disregarded the historically and structurally embedded racism within the United States, particularly in health care. The frame relied on the idea that good health care was equal health care, without targeted programs for particular populations. It is unlikely that either Andy or Nash disregarded care for Spanish-speaking patients. Their comments adhere to the ideology of racial colorblindness focusing their concerns on *all* patients rather than a particular subset of patients.

While the frame of universalism was used in reference to patient care, it was also used to discuss social networks. For example, after Leah Reaves, a middle management administrator for St. Michael's Medical Center, discussed who is likely to seek care at various hospitals around town, she discussed in an unrelated and almost stream of conscious manner various realizations she recently had: "Black managers sit together" in management forums, Black teenagers hang their pants down low "like what you do in prison," and if she hired a Black manager then she would feel left out because her assistant was Black and she was "going to have less in common and all those kinds of things." While Leah was comfortable talking about race, even sharing highly stereotypical remarks, she later stated,

> I like to believe anyway that we are a community, the St. Peter's community, that looks at people and what we care about are people treating each other the way you want to be treated and you know, going back to our team, you know, why are we here? Where are we and why are we here?

Often, teams responded to Leah's question "Why are we here?" with "We're here to serve!" Leah ignored her own prejudices and the effect her prejudices might have on potential employees by relying on a race-neutral vision of St Peter's as one community there to serve everyone. Again, whether in response to patient care or employee considerations, the frame of universalisms supported the ideology of colorblindness by relying on notions of abstract liberalism (good for the group is good for all). By providing care that ignores racial and cultural differences, administrators support the existing care delivery patterns, which provide qualitatively worse care to patients of color.

Crossing Frames - Colorblindness Through Euphemisms

Rather than avoid discussing race or referencing universalisms, some administrators relied on euphemisms to talk about race, without directly mentioning any

races. While this strategy was used least, it is a color-blind strategy where race was directly invoked without being discussed. According Leech (1981), euphemisms are "the practice of referring to something offensive or delicate in terms that make it sound more pleasant or becoming than it really is" (p. 45). The pervasiveness of the ideology of colorblindness makes talking about race taboo and suggests that talking about race only perpetuates it as an issue. One way to seemingly avoid race as a cultural issue was to implement color-blind euphemisms. Most of the euphemisms were racially coded language, subtly signifying race groups without directly mentioning any race group (e.g., "urban," "United Nations," "dangerous"). In addition to racially coded euphemisms, a few respondents used imaginary race groups (e.g., "yellow with green dots"). Euphemisms, both racially coded and imaginary race groups were exclusively used by administrators.

"Dangerous People": Racially Coded Euphemisms. Often the racially coded language was used to describe population changes. For example, when asked about changes to St. Michael's hospital over the last 20 years, Donna Neal, a middle management administrator at St. Michael's Medical Center, responded, "I don't think it's the rich population of patients now. I think we're becoming more of the city hospital." Similarly, when asked about changes across St. Peter's Seventon Health System, Andy Darling (upper management administrator for all of St. Peter's Health System) said, "Given our locations, with St. Michael's… however, I think it's more becoming an urban hospital. There are some people I think that would say demographically we serve less of the urban poor." By most standards St. Michael's is not an inner-city hospital. It is located just outside of the city boundary, in an affluent city-suburb of Seventon. There

are three other hospitals within the Seventon city limits, one that is part of the St. Peter's Seventon Health System. Both Donna and Andy signaled a change in patient demographics through the reference of the hospital as more of a "city" or "urban" hospital. The hospital did not change locations and transition into the city boundary but the patient population did shift slightly to include more people of color ("urban") and slightly fewer Whites ("rich population") that moved further from the city boundary. Other racially coded euphemisms included "underserved," "different," "scary," "dangerous," "knife and gun club," and "United Nations." Mendleberg and Olseske suggest people "use coded rhetoric that appeared universal, well-reasoned, and focused on the common good, but in fact advanced their group interests" (2000: 169). Taken out of context, none of these words reinforce the ideology of colorblindness. When used as code words to talk about race without specifically mentioning race groups, these same words reinforce the ideology of colorblindness and often still express racialized understandings (Mendelberg and Oleske 2000; Entman, 1992; Kinder and Sanders, 1996). Racially coded euphemisms align with racial colorblindness by not explicitly discussing race. Thus, racially coded euphemisms allow administrators to openly discuss race relations within the hospital and health care system and to maintain the image as colorblind.

Yellow with Green Dots: Imaginary Euphemisms. In addition to racially coded euphemisms, a few administrators created imaginary racial groups. While racially coded euphemisms served as a rhetorical strategy to talk about race without directly mentioning race, imaginary racial groups work simultaneously as universalisms, minimizations, and innocence frames. Only two administrators used this type of euphemism; however, this

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rhetorical strategy was quite effective and quickly evoked a sense of absurdity in continuing to talk as though race matters and efficiently combined the three other frames. Euphemisms were the most efficient colorblind ideology rhetorical move.

After mentioning Seventon's legacy as a "Black and White city" several times, I asked Daniel Huffman if he thought Seventon would always be known as a Black and White city. Daniel is an upper management administrator at St. Michael's Medical Center. In his response, Daniel discussed the changes he witnessed in his lifetime, particularly differences between his childhood friends and his children's friends. Daniel continued,

> "But our kids grew up… so they're much more comfortable around people who are different. They grew up in a mixing bowl or whatever... I think that changes things because people start to see that people are people and there's not that much difference, there's no difference between black, brown, green, whatever."

While Daniel used an imaginary race group to discuss universalisms ("people are people"), he relied on an image of an imaginary race group ("green" people). This rhetorical tool adhered to colorblindness through the use of a universalism (all people) while also minimizing the importance of race as a feature in social relations. Daniel also projected his own innocence through a reference to familial progress.

Similarly, Ellen Procoppio discussed firing a Black employee and the subsequent accusations of racism by hospital physicians. Ellen is an upper management administrator for all of St. Peter's Health System. Ellen said,

> What I said to both those physicians is, 'I'm not a racist. I don't care if she's yellow with green dots, she's not doing her job and she's gone.'

Ellen's imaginary race group, "yellow with green dots," was an efficient rhetorical tool that served as a minimization and universalism frame (race is not what matters, this could

happen to anyone). She began her statement with, "I'm not a racist…", which announced her innocence before she discussed the situation. Within this study, imaginary race-group euphemisms were rare and did not serve as a colorblind frame. Yet when used, they efficiently crossed all other colorblind ideology frames (universalisms, minimizations, and innocence) by minimizing race altogether (making up an imaginary race group), universalizing the experiences of various races, and by playing on naive notions of race.

COLORBLINDNESS AND RACIAL STEREOTYPES

While most participants adhered to the ideology of colorblindness, some participants also relied on racial stereotypes. According to Allport, "a stereotype is an exaggerated belief associated with a category. Its function is to justify (rationalize) our conduct in relation to that category" (1958: 87). Lippman (1922) states, stereotypes are the "pictures in our heads" we carry with us (p. 89). Stereotypes are not antithetical to racial colorblindness. Ryan, Hunt, Weible, Peterson and Casas (2007) found Whites who ideologically endorse racial colorblindness exhibited stronger stereotypes. In fact, the ideology of racial colorblindness obscures social reality in ways that prevent reflection of personal prejudice and may trick people into believing they actually do not see race (Ryan et al. 2007).

The most common racial stereotypes used by interviewees included presumptions or accusations of "illegal status," concerns around language (either demands that "they learn English" or complaints that Spanish was going to be mandated), or accusations of draining resources. Many of the racial stereotypes used also referenced Hispanics, Latinos, or Spanish-speaking immigrants as poor or uninsured. While many of these references were stereotypical in nature, seemingly exaggerated or over-used and as a

defense for lack of resources within the health care system, a possibility existed they were grounded in evidence (U.S. Department of Health & Human Services 2009; Pew Hispanic Center 2010). Therefore, I excluded any comments related to insurance status or poverty, as it pertained to Hispanics, Latinos, or Spanish-speakers.

"Taking Time Away from More Urgent Situations": the Stereotype of Resource Drainers

The most common stereotype expressed overall was the drain Spanish-speaking immigrants place on resources throughout Seventon. Since administrators are generally responsible for the allocation of hospital(s) resources, it was not surprising that more administrators than diversity committee members expressed this concern. Administrators primarily expressed concern for resources around St. Peter's Seventon Health System, such as local schools, payment of taxes (or not), and the government.

Given the context of the discussion, the stereotype of "resource drain" mentioned by administrators centered on health care. Shortly after I asked Denise Doyle, a middle management administrator at St. Elizabeth's Medical Center, about the changing demographics around Seventon, she described various concerns with the rising illegal population,

> They're not insured, so when they go to the doctor or to the medical… they come to the Emergency Room. They don't go to a physician and so they're being seen in the Emergency Room for either minor illnesses… that are taking a lot of time away from more urgent situations or being freed up for more urgent situations or… they're just, you know,… they don't have insurance. They're not being billed. [St. Peter's] is covering that cost.

Denise initially expressed that if someone was sick, it was the responsibility of the hospital to help him or her. She then suggested the primary source for health care among Spanish-speaking immigrants was an over-utilized Emergency Room, which took resources away from more urgent situations, especially paying situations. Denise's

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concern was not about the uninsured, in general, accessing health care through the

Emergency Department but a focused concern for people she perceived as undocumented

and their draining of resources.

When asked how big of an issue Spanish-speaking immigration was for Seventon

overall, Daniel Huffman (upper management administrator, St. Michael Medical Center)

expressed interests for the area schools,

> Some communities have some real issues because the tax base gets strained.
> We're paying for all these kids to go to school and they're not citizens and some
> of them aren't even paying taxes.

Denise and Daniel both utilized stereotypes of resource drainers while discussing strained

systems of health care and education. The underlying assumption for both Denise and

Daniel was Spanish-speaking settlers took more than they gave and pulled resources

away from other existing groups.

"Here Under the Radar": Stereotypes of Illegal People

Questions or assumptions about citizenship status were at the hub of the second

most common stereotype about Spanish-speaking settlers. This type of stereotype was

expressed through "illegal," "undocumented," or "under the radar" people. Discussing

individuals with an undocumented status is likely common in areas experiencing

tremendous immigration growth, yet the ways the term "illegal" emerged flags these

remarks as stereotypical. For example, West Rourke, an upper management administrator

for all of St. Peter's Health System, suggested he noticed "stuff." When I asked, "You

noticed stuff?" He replied,

> Oh yeah. I listen to the news a lot, CNN, Fox, everything you hear is California
> immigration. You can listen to Lou Dobbs every night, 'What [is] our Congress
> doing?' It's terrible. They're not sealing our borders. A hundred thousand a week
> are coming through!

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When I asked how this translated more locally, West replied,

> I see more people from India and Pakistan, and you go to Oakdale (his neighborhood), that's Oakdale/India. Are you kidding me? You live here? You know?

West's assessment was not that Lou Dobbs was inaccurate, but the issue for him was more about the local rise in the Indian and Pakistani population, rather than concerns of Mexican migration in California. Embedded in his description were assumptions of who does and does not belong ("Are you kidding me? You live here?") and a connection between Lou Dobb's concerns for immigration.

George Johnson, a middle management administrator at St Elizabeth's Medical Center, noted several changes in Seventon over the last 5-10 years, which included expansion of the city westward, loss of residents and businesses downtown, and, "a growth in the Hispanic community. There's a lot of illegals. There's a lot of them. I see them at church." George's assessment of Seventon as a whole was as a city experiencing various demographic changes. Many of the demographic changes he noted might cause alarm, such as the city expansion to suburbs at the cost of the downtown area, but none are explicitly racialized until he discusses changes in his inner network or his church. In this more personal setting, the demographic changes not only became racialized as Hispanic growth but the racialization process was linked to questions of citizenship status. For both West and George, the increased presence of particular bodies signaled assumptions of illegality. This pattern of associating Hispanic, Latino, or Spanish-speaking people with undocumented status often occurred in relation to accessing resources, but as with George and West, more frequently this happened when close, more personal settings were affected.

The third most common stereotype of Hispanic, Latino or Spanish-speaking

settlers centered around language, specifically claims of Spanish being "pushed" on

participants, immigrants refusing to learn English, or claims about people who spoke

Spanish gossiping about participants. Dave Curtis, a middle management administrator

for all of St. Peter's Health System, expressed disbelief that there was no movement in

the United States toward making Spanish-speakers learn English or speak English. When

asked about what that "movement" might look like, Dave replied,

> It's gotta be cultural change. The language you speak in this country, at least
> attempt it, is English. Don't live here for 25 years and not even know a word of
> English. Of course, you get that with some of the Oriental cultures, but usually
> it's the elderly population, not the younger population. But, even the younger
> population of Spanish-speakers, they don't attempt to speak English. I'm making
> a general statement, obviously not 100% of the people. Canadians learn to speak
> English when they come here.

Dave expressed uniqueness to "Spanish-speakers," in general, or at least uniqueness

relative to "Orientals" and "Canadians," and further articulated several assumptions about

differences in language acquisition, use, and appropriateness. Dave, like others who

expressed similar concerns, believe speaking Spanish violates U.S. norms. He earlier

stated his frustration in not being able to understand people in his own country. Dave also

presumed an active resistance among particular immigrant groups (Spanish-speaking

immigrants) compared to previous groups (Canadians). While his statement contained a

general xenophobic tone, his main focus was the violation of not speaking English.

In response to noticing changes in the demographics of her neighborhood,

Elizabeth Wright, a diversity committee member and support staff for all of St. Peter's

Seventon Health System, similarly commented,

Um, I'm not moving or anything. It's not like, 'why are they taking our jobs.' If anything, I wish they could speak English, you know? Why do I feel like I need to go learn how to speak Spanish? I feel like if they're here living, that's cool, get a job, that's cool, but learn our language. … Because, we should be… the majority is speaking English, that's my own thing, but as far as where they live or whatever, I'm fine with that.

Elizabeth's concern, unlike Dave's, was less about language acquisition comparisons to other races, ethnicities or nationalities. She spoke to a broader stereotype that this is a group pushing Spanish and not learning English, and she felt the pressure to learn their language in her country. Both Elizabeth and Dave assumed perceived race matches language acquisition and the language overheard was the only language spoken. Stereotypes centered on English use marked particular bodies as different, not a part of the general "us" or "American," and in violation of U.S. norms.

"Oh, Bring Some More!:" General Stereotypes during a Colorblind Era

The remaining stereotypes centered on general negative images or perceptions. While some participants relied on stereotypes to describe other groups of color, the focus of this study concerns perceptions of Spanish-speaking settlers. These stereotypes included work related stereotypes and general positive and negative images. Work-related stereotypes included comments like, "Hispanic men prefer outdoor work." Respondents often referred to new settlers as "hard workers," typifying a general positive image. Finally, respondents expressed a general negative image of new settlers through comments like, "nothing good sticks out."

In addition to "general" stereotypes about Spanish-speaking settlers, two focused stereotypes emerged: statements of housing density and criminality. For example, Elizabeth Wright (diversity committee member and St. Peter's support staff) responded to questions on where she noticed Spanish-speaking settlers in Seventon with,

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Um, I think a lot of them live, well… I've seen a couple in my area. I think they live, like not in a little community per se, but a lot of them are in the house more than your Black or White family. You might have four. They might have like 12 and be like, 'Oh, bring some more!' So I don't know if they have like an area, like they don't have Latino town, like China town.

While Census data shows that, on average, Hispanic or Latino households have slightly larger households than non-Hispanic or Latino household, Elizabeth was likely not simply making a general statement about differences in household density between different racial and ethnic groups. Rather, comments similar to Elizabeth's highlight how Spanish-speaking settlers are *distinctive* from existing racial groups. Participants who commented on household density often used elevated numbers or dramatic stories (such as, "Oh, bring some more!" or "they were living in sheds!"). While both Elizabeth's story and similar narratives may be true, they weave a story of "us" versus "them" and generally rely on outliers and extremes rather than patterns.

In the same way administrators and diversity committee members relied on stereotypes of housing density, several participants relied on stereotypes of criminality. Shortly after discussing demographic changes in his neighborhood, Drake Gibson, an upper management administrator for all of St. Peter's Health System, described community initiatives across Seventon to address the Hispanic community and troubles with these initiatives,

The other side of the equation is that there has been… Hispanic people identified with drugs and crime. And … what's happening there… And a fear of people in the Hispanic community. And, specifically concerns by Blacks who may be low wealth. 'Are these people going to come and take our jobs?'

Drake, like Elizabeth, characterized Hispanics as distinctly different from White people. His discussion not only implicates Hispanics as involved with drugs and crimes but also implicated Blacks as drug-related criminals who may end up competing with Hispanics.

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The comment served to racialize crime for both Hispanics and Blacks and set both apart from the "rest" (read: White population) of Seventon.

While most of the administrators strongly adhered to the ideology of racial colorblindness, some also used racial stereotypes of Spanish-speaking. Stereotypes emerged more often when areas in administrators' private lives were encroached by Spanish-speaking settlers, such as neighborhoods, schools, and churches. Administrators use of stereotypes likely functions as a way for them to make sense of the community's demographic changes from a rigid Black-White town with established, yet tumultuous race relations to a community experiencing rapid growth of a new race group.

CONCLUSION

Whites used three frames (projections of innocence, minimizations, universalisms) and one frame-crossing strategy (euphemisms), to simultaneously acknowledge and disavow participation in race relations. By removing themselves as part of the problem, Whites actively participated in the possessive investment in whiteness and maintained their position in the racial hierarchy. Frames that support the ideology of colorblind racism dismiss the ways race is deeply embedded in structural arrangements. Colorblind racism, as a hegemonic ideology, is not neatly packaged or visible but often shifted throughout conversations. The three most common frames (universalisms, minimizations, and projections of innocence) serve as the audible building blocks of the ideology of colorblind racism. Colorblindness, in turn, impacts the quality of patient care by preventing administrators from examining the influence of race personally and structurally within the health care system. First, participants who utilize the frames cannot challenge the existing racial ideology. Second, participants who espoused to serve

"all patients" did not have to critically examine patterned disparities in service that fall along various social locations, particularly race lines. Third, participants who minimized the importance of race ignored the historical and structural legacy of racism. Fourth, participants who framed themselves as innocent – through one's job description and responsibilities, accounts of racial progress, projections of naivety, or simple denial – eschewed personal responsibility in reproducing or reducing unequal outcomes. Finally, colorblind euphemisms served to efficiently cross various frames by both acknowledging and denying race.

Most participants adhered to frames of colorblindness; however some also relied on racial stereotypes. These stereotypes often emerge when the dominant group's position in the racial hierarchy appears threatened (Rodgers n.d.). The central elements of racial colorblindness are not necessarily violated when discourse becomes explicitly racialized. Rather, individuals who deeply believe in the ideology of racial colorblindness may also be blinded by their own racialized understandings, particularly racial stereotypes. For some administrators and diversity committee members, stereotypically suggesting new Spanish-speaking settlers are "illegal," "take resources," or "refuse to learn English" may seem like non-racialized understandings but merely as factual accounts. Additionally, the ideology of racial colorblindness suggests that people are supposed to be race neutral, not that they actually are. Therefore, it is not surprising for racial prejudice to bleed through the veil of racial colorblindness.

The discursive maneuvers of administrators at St. Peter's Seventon Health System serve to solidify racial colorblindness as a hegemonic ideology. While individual participants expressed colorblind and often stereotypical sentiments, the pattern of

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discursive frames is central to the maintenance of colorblindness as an ideology and to the continuance of existing structural arrangements. Most of the participants expressed at least one colorblind frame, although the frequency of use varied. The use of both racial colorblindness and racial stereotypes worked to distinguish between racial and ethnic groups. In this case, both racial colorblindness and stereotypes work to separate new Spanish-speaking settlers as markedly "different" from the existing groups and inferior. Consequently, the ideology of racial colorblindness prevents administrators from seeing how race influences the quality of patient care and from investigating ways personal racial biases effect patient resource distribution.

CHAPTER IV

ALL PATIENTS ARE THE SAME, UNTIL THEY BECOME

NEIGHBORS: RACIAL HIERARCHIES IN A COLOR-BLIND ERA

In 1903 W.E.B. DuBois stated the problem of the 20th century was the problem of the color line. For DuBois, the color line was "the relation of the darker to the lighter races of men in Asia and Africa, in America and the islands of the sea" (DuBois 1903: 10), or the binary racial hierarchy of White to Non-White. DuBois's prediction continues to echo and endure into the first part of the 21st century even while scholars contest various theories and iterations of the color line. While some suggest a shift in the racial hierarchy, or color line, from the bi-racial order noted by DuBois to a new racial hierarchy, the enduring legacy of the color line remains in the United States. In this chapter I explore how the color line, or the boundary that separates access to resources and services between particular groups of people based on their racial group membership, was expressed in discourse among the St. Peter's Seventon Health System administrators and diversity committee members. I argue existing theories on the color line fail to capture the perceptions of the health care administrators and diversity committee members in Seventon.

As mentioned in Chapter III, Seventon is both a New Latino Destination and a Pre-Emerging Gateway for settlers and, therefore a site for two related emerging demographic trends: new development of and quickly growing settlement communities for Latinos and immigrants in the United States. Seventon, located in the Southern Atlantic, remains deeply rooted in its Southern heritage and culture, particularly its role as an influential Confederate city. While romanticizing its role in the past, Seventon is

also characterized by its Southern hospitality. Health care administrators are no exception to this paradox of racially embedded local history and efforts to be seen as a proper "southerner." The stakes of proper "southernness" seem to rise in tandem with one's occupational status, as it is particularly important to mark oneself as different from improper southerners or "rednecks" stuck in the past. This paradox also played out in ways health care administrators and diversity committee member discussed the rise in Spanish-speaking immigrants. Participants were conflicted in their discussion of race, as there was a level of politeness associated with discussing race, especially in marking oneself as the proper southerner. But, the politeness waned as administrators discussed how local demographic changes influenced their personal lives and for some, it also diminished when discussing St. Peter's Seventon Health System resources.

PROBLEM OF THE COLOR LINE

In an address to the National Colored Convention in 1881 Frederick Douglass (1955) stated, "Out of the depths of slavery has come this prejudice and this color line…. Slavery is indeed gone, but its shadow still lingers over the country and poisons more or less the moral atmosphere of all sections of the republic" (p. 348). Douglass (1992) continued by noting the ubiquity of the color line and its impact on all aspects of "progress," from labor to service to accommodations. His address noted the common practice of preferential treatment or differential treatment based on race lines following the passage of the 13th Amendment and demands for equal civil rights to all persons regardless of race. Douglass's statement on the differential treatment based on race, rather than individual merit, endures and remains pivotal to understanding the significance of race in the United States.

As previously noted, twenty years following Douglass's comments to the National Colored Convention, W.E.B. DuBois (1903) stated, "The problem of the twentieth century is the problem of the color-line, the relation of the darker to the lighter races of men in Asia and Africa, in America and the islands of the sea" (p. 10). His observation continued as an often-cited examination of the contemporary race relations, a noted warning toward the future and as a reverberation from the past. DuBois' understanding of the color line pushed beyond the Black-White paradigm of Douglass and calls for greater awareness of the relationships between all race groups.

More recently, Omi and Winant (1994) have argued, "Racial dictatorship organized (albeit sometimes in an incoherent and contradictory fashion) the 'color line' rendering it the fundamental division in U.S. society…. not only through institutions, but also through psyches" (p. 66). This line that differentiates treatment, service, and opportunities on the basis of race is the legacy of the historical racial dictatorship in the United States noted by Douglass. Yet as Omi and Winant argued, it remains in both structural arrangements and individual psyches. Douglass optimistically forecasted that, "Assisted by time and events and the growing enlightenment of *both races*, the color line will ultimately become harmless…. It will cease to have any civil, political or moral significance" (Douglass 1922: 702). While Douglass's remarks were hopeful, the color line shifts over time and remains an enduring feature of United States race relations. As the racial distribution, either perceived or real, of the United States changed, so did the understanding of the color line among scholars.

Following Douglass and DuBois, contemporary race scholars continued to theorize on the demarcation of the color line in the United States. The three contemporary

conceptualizations of the color line in the racial stratification literature are: a White/Non-White divide, Black/Non-Black divide, and a triracialized system. These three approaches, in my view, all have shortcomings. All three approaches fail to capture the discourse and perceptions of health care administrators and diversity committee members and their expressions of racial hierarchies, which often conflicted depending on the arena of conversation. Contemporary discussions of the color line describe it as a static, inflexible line marking hierarchical arrangements between racial groups. The color line emerged in different ways to administrators, such that lines that were seemingly invisible at work were easily mapped out in someone's personal life.

The White/Non-White Divide

The White/Non-White divide or racial stratification scheme emerged from theories to explain the earliest racial interaction in the United States. In order to protect their own material interests, the ruling class solidified boundaries among Whites and between Whites and people of color through race-based policies of the state (Omi and Winant 1994). Despite episodes of cross-racial unity and solidarity, the racial state provided access to services and resources differently based on racial group membership. Of particular importance in the development of racial hierarchies in the United States was slavery. Subsequent laws provided rights to citizenship and its associated resources shaped succeeding racial hierarchies. While the White/Non-White divide explained race relations in early America, it fails to adequately address race relations today. Health care administrators and diversity committee members in my study did not view the world as simply White or Non-White. Rather, they marked meaningful differences between various racial groups. While many administrators and diversity committee members did

express "us" versus "them" sentiments, they also distinguished between the "them" rather than expressing the out-group as a monolithic entity. For example, administrators were quick to note where different racial groups lived in Seventon. In this mapping of racial geographies, different racial groups did not seem to occupy similar areas; there was the "Black" part of town, "Asian" part of town, growing "Hispanic" part of town, and newly emerging "Indian" part of town. Whites were often dropped from racial geographies, except to note where the exceptionally affluent Whites or "poor White trash" lived. By marking off separate racial geographies, administrators did not consolidate a "Non-White" racial group but noted differences between racial groups.

The Black/Non-Black Divide

Some scholars suggested a Black/Non-Black divide emerged in the United States following the Immigration and Nationality Act of 1965. Lee and Bean (2007) argued post-1965 immigrants to the United States would eventually attain whiteness through the expansion of the White racial category. The suggestion was that post-1965 immigrant groups would "assimilate" into the American mainstream similar to earlier waves of immigrant groups. Previous immigrant groups considered under this paradigm were ethnic Europeans, like Irish or Italians, who were once considered non-White (Ignatiev 2009; Roediger 2007). Lee and Bean's (2007) argument followed traditional assimilationist views of race and ethnic relations in the United States and failed to capture lived experiences and the complex web of race relations. Additionally, immigrant groups today are far less homogenous in race and class background than immigrants of the past (Telles 2010). Consequently, Lee and Bean (2007) suggest the fundamental distinction between access to resources lies between Blacks and Non-Blacks. However, health care

administrators' and diversity committee members' perceptions are much more nuanced.

Denise Daniels explains the effect of the changing demographics in Seventon as,

> Well, now the Hispanics are at the bottom of the ladder instead of the African-Americans. The wrath has turned toward, you know, so the White and Black workers can say, ah, got to get rid of those Hispanics.

Denise's description does not rely on a Black/Non-Black view of race relations. She sees divisions, including access to jobs, beyond a Black/Non-Black binary. Lee and Bean (2007) contend this binary is the fundamental division in the United States; however administrators' perceptions push beyond a simple binary division.

Triracialized System

Bonilla-Silva (2002) suggested a tri-racial system of race relations emerged in the United States following the civil rights era. Changes in racial demographics, racial attitudes, and the globalization of race relations, data collection, and race-based social policy resulted in a change in the structure of race relations from a bi-racial order to a tri-racial stratification. Further he argued this newly emerging tri-racial stratification is comparable to other racial hierarchies throughout the world where "Whites" are at the top, followed by "honorary Whites" and then "collective Blacks." Bonilla-Silva (2002) contends race lines, or this newly emerging racial order, in the United States is based on skin tone while also incorporating other "objective" (income and education), "subjective" (attitudes and racial classification), and "interaction" (marriage and segregation) indicators.

While many theorized about the transformation of color line, racial division in terms of access to resources and opportunities remain despite legislative efforts. Additionally, current theoretical understandings of racial stratification via the color line

have not fully captured the complex reality of contemporary race relations. Rather than a single color line, I found health care administrators' understandings to most closely align with Bonilla-Silva's triracialized system. However, they view the color line differently based on the arena of conversation, such that people often expressed different understandings of the color line between their personal and professional lives. Furthermore their discourse framed the color line as flexible and moving. Existing theories of the color line do not fully capture the normative views of race expressed by health care administrators. Peoples' general understandings of the color line were shaped by the dominant discourse of race neutrality (as discussed in Chapter III) and a heightened sense of demographic change in their local city rather than "objective" progress indicators, such as segregation indices and income disparities. Thus, while the conceptualizations of the color line discussed above all rely on material indicators, administrators' and diversity committee members' perceptions push beyond just material and objective indicators.

RESULTS

The literature on racial stratification in the United States suggests the color line manifests in one of three ways: White/Non-White divide, Black/Non-Black divide, or as a triracialized system. However, I found racial understanding which reflect a far more complex reality than these contemporary race theories describe. People do not discuss race simply as a division between two or three race groups but shift the color line differently based on the arena of conversation. Health care administrators' perceptions varied depending whether they were discussing their professional or private lives. Expressions of this change were evident in these three areas: demographic changes, shifts

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in resources, or understandings of group boundaries. In their professional lives, participants expressed race neutral views of patients and of the color line. However, as Figure 1 illustrates, when the conversation shifted away from their professional lives and into their private lives, the same administrators were racially cognizant and expressed hierarchical understandings of the color line.

Figure 1. Transformation of the Color Line Across Conversation
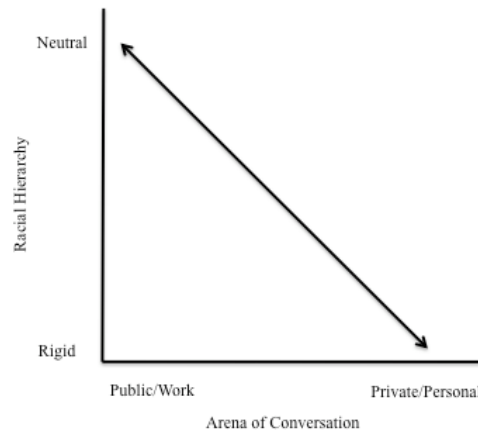
Changing Demographics

All administrators and diversity committee members noted the changing demographics of their community and most readily provided examples of where they saw these changes occurring. However, many of those same participants were far more reluctant to note how those changing demographics were impacting their professional lives, or to advance suggestions for the health care system to capitalize on those changing demographics. Administrators expressed paradoxical views of racial awareness in their personal lives and racial neutrality in their patient policy decisions.

Participants made comparisons between the past and the present when discussing changes occurring around Seventon, particularly noting a change from Black-White

history to a more multicultural population ("the world is changing"). While it may seem somewhat surprising that people willingly admitted to noticing changes in the demographics of the city, ostensibly a violation of the dominant colorblindness, it was inconsistent when and where respondents were aware of those demographic changes. Some administrators were seemingly unaware of demographic changes in their patient population, yet were hyper aware of changes in their everyday lives outside of work, such as in their children's schools, the grocery store, neighborhood, or local shopping mall. This pattern of not seeing race in the hospital but noticing it outside of work occurred only with health care administrators, while diversity committee members were consistent in their awareness. Diversity committee members were better able to name changes because demographic changes were discussed at committee meetings and they were interviewed because of their role as diversity committee members. The response below by Sharon Buren, an upper management administrator who floated between St. Josephine Medical Center and St. George Medical Center, was typical of White administrators. When she discussed the types of patients seeking care at the different hospitals her expression was completely colorblind: "when you're a clinician, what matters is what are you supposed to do for that patient and you don't pay much attention to ethnicity." Like most administrators, Sharon was adamant she saw no difference between different patients in the hospital. However, as our conversation progressed and shifted away from her work experiences and to the differences between her time in school growing up and her child's classroom, she shifted away from her ideas of colorblindness to more racial awareness:

> I can honestly say I grew up in pretty much White, an occasional… as I got older more, at that time, Black. But now, my kids, their classrooms are very diverse so yeah…. Obviously Black and White, Asian. I think that's probably it.

She continued by noting everywhere in town was more diverse than when she grew up; even the grocery store now carried foods with Spanish writing. Sharon's initial analysis of patients' needs ignored race, despite her racial awareness within more personal settings, such as her daughter's school. After acknowledging racial differences between her childhood classroom and her child's classroom, I asked her to again return to work and to discuss how those differences emerged. Sharon initially continued her colorblind position but switched to a far more complicated and conflicted view of racial awareness: [Patients']… "needs are different. A patient is not a patient is not a patient. But also having said that, I think there's also—my personal philosophy is a patient is a patient is a patient." Sharon was torn between two worlds: race cognizance and colorblindness. While she saw differences and changes in the demographics in her private life (her child's school and the grocery store), she also tried to espouse ideas of race neutrality and tolerance through racial colorblindness at work. She seemed unwilling or conflicted to relinquish the popular notion of colorblindness for racial awareness within her work setting, but she was at ease when discussing racial differences in a more personal setting. While she noted the changing demographics within the city, "my kids, their classrooms are very diverse," Sharon seemed unsure how to translate those changes to her workplace. She eventually attested that at one of the hospitals the patient population is changing:

> That's an inner city underserved population so that majority of what we're seeing there is Black, Hispanic, poverty level or close to poverty level people. The demographics for St. George's certainly contain a portion of that but not nearly at the level that St. Josephine's does. … We call them treat and street because

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they're like doctor's office visits. … It's just an ER term, like a fast track. It's not a high level of testing, not a high level of skilled clinician care needed.

Her initial uneasiness could reflect the health care system's policy of providing care to all patients and a concerted effort to appear race neutral to mark herself as different from the stereotypical racist Southerner. Sharon's discussion of patient demographics and treatment began as seemingly race neutral at work, where all patients were treated the same. Yet, when our conversation shifted away from work, she moved toward more racially cognizant. Sharon did not overtly connect demographic changes to a racial hierarchy, but she was uneasy expressing racial awareness at work and eventually discussed a different kind of patient care provided to particular patient groups (inner city, underserved Black, Hispanic, and poor populations). As Pollock suggested, "people talking in de-raced terms as if race does *not* matter often expose the ways in which race matters to them most explosively" (2004: 43, emphasis in original). It is likely race matters for Sharon at work, perhaps in ways yet unexamined by her and to the health care system. The ideology of racial colorblindness encourages both Sharon and the larger health care system to not examine the ways race matters for the organization.

Not all administrators were as conflicted about the changing demographics within the community. A few administrators, such as Jack Bear, also noted the town's changing demographics but conveyed more comfort with the corresponding changes. Jack is an upper management administrator in charge of the St. Peter's Seventon Health System's Mission Department, including diversity initiatives, the mobile medical outreach unit; he also supervises the manager for Hispanic and Cross-Cultural Health. Jack mentioned the influence of this Southern town's history alongside increased awareness of changing demographics:

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> Seventon is in some ways still a prisoner to the racial strife and the simple division of Black and White that it has had for years, but that is shifting. You can't travel on a plane without the safety message being in Spanish as well as English.

Jack believed people within the organization were not as aware of the changing local demographics since they were "a prisoner to the racial strife" of the past and, in part, because of the admittedly poor communication between his department and the rest of the health care system. As the department leader, which included the manager of Hispanic and Cross-Cultural Health, and other outreach coordinators, Jack expressed an interest in having his office be racially progressive and aware. Despite his efforts, Jack also fell into stereotypical racial characterizations and believed the increased presence of Spanish-speaking patients in Seventon offered the health care system a natural competitive edge:

> From a business case, if we are not seen now as sensitive to the needs of Hispanics then we are missing huge potential market share, a growing market share, and that's just stupid. We have a *natural advantage* over every other system in the region because we are Catholic faith based and there is still a strong traditional Catholic emphasis within the Hispanic community.

While Jack saw the shift in Seventon as moving beyond the Black/White paradigm of the past, he also saw this shift directly affecting the health system with a positive business development opportunity. It is interesting to note Jack's awareness of a potential edge in the market based on Catholicism compared to his earlier suggestion that the weakness in capitalizing on this market stems from a lack of communication from his department to the rest of the health care system regarding this competitive advantage. Like many administrators, he is aware of the changes in demographics but during an era of racial colorblindness, seems to not know how to respond to these changes. Jack's readiness to discuss the changing demographics stands in stark contrast to Sharon's reluctance, but both express stereotypical views of Spanish-speaking patients and service distribution.

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Jack viewed the Hispanic community as a business opportunity because of the *natural advantage* stemming from stereotypical assumption that most Hispanics are Catholic and would therefore prefer a Catholic hospital. A recent Gallup Poll (2005) study did not cite religious affiliation as one of the top ten influences on hospital selection. Rather, hospital expertise, medical history, and physician referral were among the top influences. Additionally, as noted earlier, St. Peter's Seventon Health System, receives disproportionately fewer Hispanic in-patients than the other local hospitals. Like other hospital administrators, Jack relies on stereotypical understandings of devout Catholicism among Hispanics in order to sway hospital selection. Similarly, Sharon presumes Hispanic patients rely on hospitals, rather than primary care offices, for routine care. While both Jack and Sharon are aware of the changing demographics, racial colorblindness seems to prevent both from examining service opportunities to correspond to those changes.

Shift in Resources

The color line also emerged in conversations with administrators in the ways they discussed shifts in available resources. Some administrators and diversity committee members saw the future needs of the hospital(s) as minimally or unaffected by the changing demographics while others viewed the changing demographics as requiring a large shift in resources. Resources included charitable care and outreach programs, diversity efforts, signs, brochures, and translation services. Melanie Bartlett, a middle management administrator at both St. Josephine's Medical Center and St. George's Medical Center, noticed a slight change in the patient demographics in her hospitals. She noted the change in patients was primarily driven by one OB/GYN practice's recent

recruitment of bilingual nurses. While she thought the changes were a "good thing" for

the health care system, she also noted the new patients were from outside the city and

from more rural areas, not a place where the system currently has a strong presence.

Rather than seeing this as a market expansion or business development opportunity,

Melanie seemed more tentative. For example, when discussing renovation projects at her

hospital, I asked Melanie and her supervisor if the changing racial composition of the

service area to now include this new patient pool influenced any of their decisions, such

as bilingual signs. Melanie and her supervisor Will Peppercorn (upper management

administrator for St. Josephine's Medical Center and St. George's Medical Center)

responded:

> Melanie: That would be something we probably should look at, especially when
> we think of the physician groups that are offering the service and if they're going
> to send their patients this way we need to be able to provide that, like Monarch
> Women's Center for example. All their staff is bilingual. If they're getting patients
> from the Katelynton area chances are they're going to deliver their babies here. If
> they're Spanish speaking how are we accommodating them from a signage
> perspective? I mean, I don't know what it's like up in [labor and delivery] from a
> bilingual standpoint. We have the phones. We have all that in place, but I don't
> know how welcoming that is.
>
> Will: I don't think we need …anymore.
>
> Melanie: No… I don't think it's grown that much, but the Oysterville Valley
> (adjacent community) is certainly growing.

For these two administrators the healthcare facility had not yet reached a point to adjust

services or signage to reflect the demographics of their community or patient population

base. Melanie's tentativeness in discussing race was very typical among administrators.

Melanie did notice a change in demographics, particularly in an adjacent community. She

also noted the current infrastructure may not be very welcoming but quickly followed her

boss's dismissal of adding new resources to accommodate the growing Spanish-speaking

population. Thus, Melanie was aware of the growth in Spanish-speaking patients at a local women's center and its subsequent growth in deliveries at the hospital but had not investigated if additional resources were needed to accommodate this patient population. The dominance of the ideology of racial colorblindness likely blocks both administrators from discussing race at work. As a consequence Melanie and Will placed Spanish-speaking patients' needs and available resources as a lower priority for the hospital while deflecting responsibility to a nearby community.

In her personal life Melanie expressed concerns about going to Walmart at night because no one spoke English anymore. She was noticeably unsettled when she discussed the changing demographics in the city:

> I see them at like, Walmart, Target always. When I realized that it was sort of a boom is that one time I went to Walmart and I literally felt like everyone was speaking Spanish, like on a Saturday morning and it was just filled with folks. I'm like, what in the world, and that's when I started to realize there was a boom happening in Seventon. Back to the construction thing, like, you go to any Home Depot at any certain time I've always seen quite a number of Hispanics there.

When we returned to the topic of work to discuss the demographic changes further, Melanie noted a similar level of discomfort, particularly in shifting the facility's resources:

> I think sometimes we focus so much on the Hispanic population and the growing Hispanic population that we're forgetting about those who are in the Whitaker Courts and the Skinner Courts, in those areas where they have the same challenges as far as access to care, but just in a different way…. I've seen the trips to more African-American areas decrease while they're going to the more rural communities to provide care to the Hispanic speaking population. So it's sort of taking away…

Melanie had a distinct zero-sum game argument for resource distribution where resources were taken away from the predominately African-American part of town and shifted toward the predominately Hispanic parts of town. For Melanie, demographic changes

represent conflicting strands: good when they brought in new business but less desirable when it removed resources from existing groups or when it used revenue, like bilingual signs. Melanie's response clearly shows her struggle with how to adjust services to a new subset of patients and community members, a group which is altering the existing race relations.

Other administrators noted the shift in resources related to human resources rather than physical or medical resources. Michelle Harmon, middle management administrator at St. Michael's Medical Center, has worked in Human Resources for about fifteen years. When I initially asked her about changes in the patients over her work tenure she noted the increased prevalence of obese patients and its impact on nurse retirement and nurse turn-over. After our conversation shifted from work to her personal experiences with other changes in Seventon, she described a change in her neighborhood from the older, more established White families moving out and younger, more diverse families moving in. She also said as she drove around town she saw an increase in "Mexicans." This awareness led her to suddenly remembering and excitedly reporting changes at work too:

> Well, a lot of Mexicans and I don't remember seeing that when I first moved here 25 years ago, a large Mexican population. That's something that interests me. … You know, I have a very diverse employee population too! And of course we have White persons. We have Asian. We have African-American. We have Native American. And so I think just within employee lines in the [division], and I think that's good. The only thing we're low on is males.

Upon further conversation, Michelle's initial excitement for diversity faded as I asked how those changes impacted her job. Michelle noted it was a luxury to have a more diverse employee base but the diversity also takes more time for her to do her job:

> We have more diversity than we had 15 years ago… which I think is really interesting. And we tease about this because to have just a Spanish employee is a luxury because, I mean, there's a lot of people that speak Spanish today, and if

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they don't speak English then there's lots of resources to help you. But we're seeing all these Middle Eastern countries and all these different African countries and Bosnia and just, you know. So the challenge for us, I mean, you can imagine…. I mean, it takes more time. We know that. It takes more time.

Both Michelle and Melanie became far more animated about demographic changes when they discussed how this impacts work-related resources. Michelle initially gave the impression that diversity at work was a good thing, indeed something to get excited about. This level of excitement tempered when she discussed how the training of bilingual staff took more of her time than the "English-only" staff. Not surprisingly, both Melanie and Michelle expressed conflicting views on the emergence of Spanish-speaking people as both patients and community members. They both expressed relative awareness of the benefits of diversity, such as for increased market potential and as a human resources benefit, but simultaneously relayed concerns for how resources within the hospital were distributed and how this demographic trend influenced their personal lives. Health care administrators face these demographic changes in an era where talking about race risks being perceived as a racist. Additionally, as new settlers arrive in Seventon, racial hierarchies in place for centuries are now affected. The conflict expressed by administrators consequently influences a sense of uneasiness with shifting resources to a newer group.

Understandings of Group Boundaries

Finally, the color line emerged in conversations with health care administrators in the ways they discussed group boundaries, including boundaries of difference and the openness of the world today. Most administrators and diversity committee members readily identified where different racial groups lived in Seventon. The racial mappings often happened through hand gestures used to divide the city among boundaries of

difference for racial groups. People could identify where race groups lived, shopped and frequented based on understandings of group boundaries of "us" versus "them." There were places where members of your "us" group went and places designated for "them" and descriptions were rigid and segregated.

Colton Parsons, middle management administrator at St. Michael's Medical Center, was born and raised in Seventon. While Colton is relatively new to his job, he was able to discuss changes in the city over his lifetime, including overall city growth and a growth in Latinos. When he discussed the growth of Latinos in Seventon he drew out a map with his hands, noting street names for boundaries where certain people lived. I asked him if those changes also impacted his own neighborhood:

> I'm certainly by no means prejudiced or racist or anything at all, but in actuality when it comes to sociology and the need to feel assimilated or a part of something is so strong, that groupings can be found in everything… there's a corner of our neighborhood that was not torn down and rebuilt, they are smaller homes, still nice homes and all that, but they're just not part of the new neighborhood, so I always found it interesting in that corner, it's mostly Spanish speaking and nowhere else in the entire neighborhood including the town homes and everything else, there's not such a grouping like that…

Colton expressed concern that to notice race is to risk being seen as prejudiced or racist. Colton suggested that everyone's desire to be "part of something is so strong." However when he discussed how this desire emerged it fell along race lines rather than any other type of social identity. This semantic move ("I'm certainly by no means prejudice or racist") sanitized Colton's understanding of racial segregation. Colton marked off boundaries in his neighborhood for the "mostly Spanish-speaking;" this is the area where *they* are and nowhere else. Administrators often relied on semantic moves like Colton's in order to express racialized understandings while first eschewing their culpability as

racists. Continuing our conversation further, I asked if those neighborhood differences

impacted other areas of Colton's life, like shopping or dining:

> My wife likes to make Mexican lasagna, and they have everything we need when
> we go in to the grocery store. We don't need to go to a specialty grocery store.
> There might be a matter of comfort in it for the Spanish speaking population to go
> into places they feel completely comfortable and do some shopping in their own
> and maybe they do have some issues with the English language and don't
> understand it all and they don't have to worry about it and choose to go to their
> grocery store instead of the other grocery store. They could easily feel lost.

For Colton the demographic changes in the area literally hit close to home. He is aware of

geographic boundaries between groups and continues to demarcate those boundaries

through his imagination of the city and his neighborhood but also through this sense of

racial group identity and membership. Colton has clear understandings of what it meant

to be a member of his race group, which is different from this newly emerging racial

group. The older side of his neighborhood and the Mexican grocery store is for "them"

while the newer side of the neighborhood and grocery store chain is for Colton's "us."

And for Colton, any deviation between those clear boundaries may lead one to feel "lost."

While expressing the appropriateness of connectedness between people ("the need to feel

assimilated or part of something so strong"), Colton is clear about who fit into this

cohesive group, and it does not include the Spanish-speaking residents of his

neighborhood or shoppers in the local Mexican grocery store. As Blumer (1958)

suggested, Colton defines his "us" group in opposition to the newly arrived Spanish-

speaking settlers.

Ellen Procoppio, an upper management administrator for all of St. Peter's

Seventon Medical Center, discusses changes she has seen across Seventon. Ellen

describes herself as having a diverse network of friends (she doesn't care if you're

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"yellow with green dots") and as being progressive. Ellen has worked for the health care system for over twenty years and prides herself on her awareness of the continual changes throughout the system. However when I asked her about what types of patients go to the different hospitals across the system she notes:

> I have to share with you, that lately, I have noticed around St. George's, I live in Waltonville, far out east, but I have noticed since the shopping center has opened out there, [shopping center name], even the movie theater, we won't go to a show in the evening because there are a lot of dangerous looking young people out there. So I've noticed Waltonville, around the shopping mall, maybe not at the hospital, there's a Wal-Mart out there's one on the Route and one on the Turnpike, I think the city is starting to migrate that way. I don't think you'll see that at St. George's. I think you'll see a Black population at St. Elizabeth's, probably not as much because we don't have bus service at St. George's or St. Elizabeth's.

While I questioned Ellen about differences between patients at each of the St. Peter's different hospitals, her reply marks off the city where the "dangerous people" live, those newer developments where a major road divides the landscape and aides in the creation of boundaries. Ellen also uses the bus route to mark off boundaries of race and class difference, particularly relative to where she lives. While proud of her diverse network of friends, Ellen is particularly cautious around the predominately Hispanic and African-American parts of town and is careful to note the distance between her home and those areas. Ellen also notes how demographic changes relate to different facilities so the Black population is more likely to go to the hospital located in the inner city because of bus services but not the more suburban facilities. Ellen curiously ignores the other St. Peter's Seventon Health System city hospital located on a bus line but instead focuses on where "dangerous people" (her code for people who live in a predominately Hispanic and Black part of town) congregate and the hospitals they utilize.

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While the majority of respondents note a rigid boundary of difference between their "us" group and the "other" race groups, this sentiment is not universal. Beth Schorte, an upper management administrator at St. Michael's Medical Center expressed very different concerns than either Ellen or Colton. Rather than expressing concern over the existence of boundaries, Beth worried about the lack of boundaries:

> I mean, you know, you just kind of walk around and you can notice it. Different languages, and I mean, I think that's very different… the worlds just opened up. There's so many more folks all over the place. I mean, I've never been to New York and we went there a few weeks ago, but I mean, honestly, I… we were one of the few people who were speaking English! I said that to my kids. You heard French, you know, Ind… you know, people from India, you heard Spanish all over the place, there were Asian dialects, you know, I'm thinking, "OH MY GOSH, we're like the only people speaking English!" And my oldest daughter, said, she, cause, we're in New York, and I was like "What?" And I'm thinking I've never been in a place so wild in my life… all these people and things flashing, and she said, "Mom, think about", because she's been to Europe twice, she said, "Think about being in a city like this and you're the only person speaking English and everyone else around you speaking French and German", that's where she went, and I'm thinking, wow, that's weird. And down the block I'm thinking it's not that different than what you're saying. So… I just think the world, we're just, there's no boundaries anymore. I mean, people are just everywhere.

Beth's understanding of the boundaries draws on an understanding of a relatively stable racial hierarchy and arrangement that is falling apart. Beth's body posture and the tone of her voice shifts when she relays openness around her. Beth is very reserved when we discuss her work life and daily routines. However, she transitions from a closed position in her seat to a far more animated speaker with her arms flailing about and her intonation shifts from subdued to amplified and excited when we shift from discussing work to changing demographics. While seemingly in contradiction to Ellen or Colton, Beth's understandings also mirror a change in demographics, which affect racial boundaries and rely on racial stratification. Beth's response is predictable and understandable as she

grapples with the changing demographics. She seems very uncomfortable with the changes brought by the demographic shifts and she seems to yearn for more rigid boundary distinctions. For Ellen, Colton, and Beth the demographic changes within the community clearly influence their understandings of group boundaries, but they are limited in the ways they can discuss these changes, particularly by the dominant ideology of colorblindness. For all administrators, discussing race risks being perceived as prejudiced but the demographic changes are occurring around them and are impossible to ignore. Even during an era of racial colorblindness, administrators quickly make distinctions between "us" versus "them," though responses range from rigid boundaries to concern for a lack of boundaries.

CONCLUSION

The research literature suggests the current color line has shifted away from the Black-White binary to a White/Non-White divide, a Black/Non-Black divide, or to a triracialized system. However, the research presented here suggests people's understanding of the color line is more complicated and often shifts based on the arena of conversation (work versus home). The dominant ideology of racial colorblindness coupled with the racial history of this Southern town emerge as blocks for administrators: how does one talk about where a new group fits into existing racial hierarchies when discussing race is taboo? It was easier for administrators to discuss demographic changes they noticed in their private lives but far harder to consider how those changes affected their professional lives. The discourse of race suggests the change in the color line through a change in demographics, shift in resources, and explication of group boundaries. People are very clear and aware of differences between their own group

("us") and other group ("them") boundaries. Current understandings of racial

stratification extend beyond the Black-White paradigm, but do not fall neatly along a

Black/Non-Black divide, White/Non-White divide, or include Spanish-speaking settlers

as an honorary group, collective White, or collective Black. Perhaps the problem of the

twenty-first century is still the problem of the color line, but it is a line which ebbs and

flows throughout conversations depending on the topic at hand (work versus home). As

Frankenberg suggests, "the boundary between white and black shifts but remains intact"

(2005: 96). In the same way the ideology of racial colorblindness flexibly shifts, the color

line also moves.

Most administrators and diversity committee members demarcate differences

between Spanish-speaking settlers and existing racial groups in Seventon. While racial

cognizance is desirable, especially relative to racial colorblindness expressed in the

previous chapter, common expressions of racial cognizance follow selective engagement

rather than no engagement. According to Frankenberg, this type of selective color-

evasiveness is contradictory, appears anti-racist, but leads people "back into complicity

with structural and institutional dimensions in equality" (2005: 143).

The administrators and diversity committee members of St. Peter's Seventon

Health System selectively engage with the changing demographics and the available

resources. While they selectively engage with the changing demographics, administrators

and diversity committee members are far more willing to racially map out the

geographies of difference across Seventon. Because the mapping of racial boundaries or

geographies of difference occur more often in conversations about their private lives

rather than through conversations of their professional experiences, it likely indicates

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personal preferences rather than institutional restrictions. Mapping of racial boundaries or geographies of difference in one's personal life is less complicated than mapping out boundaries related to one's profession. When discussing boundaries in their personal lives, administrators are free to express their own opinions but when discussion how boundaries emerge at work, administrators are not only speaking of their personal preferences but also speaking on behalf of St. Peter's Seventon Health System. Thus, the stakes of discussing race within St. Peter's is far more complicated and weighty than discussing race relations in their persona lives. However, these same preferences that mark off areas of comfort and desirability, and who belongs where throughout the city, are apt to influence their desired distribution of resources within the health care system. Administrators and diversity committee members who believe the health care system has not yet reached a "tipping point" for distribution of resources or for a concerted effort to examine utilization patterns or needs, by default, reinvest in the existing racial hierarchy. Finally, while the discourse surrounding the color line, as expressed through the changing demographics, shifts in resources, and group boundaries, provides more support for a triracialized system, the line is flexible and moves depending on the arena of conversation. This flexible color line also serves as a rhetorical tool to emphasize and deemphasize race at particular moments and thereby does not actively deconstruct existing structural arrangements.

CHAPTER V

PIMP THE MISSION TO PUSH THE MARGIN: CHARITABLE

PROGRAMS AS RACIAL PROJECTS

Like most people in the United States, health care administrators struggle with how to talk about race. The dominant ideology of racial colorblindness encourages people to ignore race and believe Dr. King's "dream" was realized. As a consequence, people often fear talking about race will make them appear racist. Administrators in Seventon faced the additional risk of being seen as stuck in the Confederate past and in alignment with the Southern "good ole boy" network. This consequence is particularly prominent in conversations about Spanish-speaking patients where administrators toed the line of "hear no race, speak no race, and see no race." However, when conversations shifted from their professional to their personal lives, the proverbial veil was lifted. Talking about race, particularly mapping racial boundaries, seemed to become easier. Administrators also spoke more freely at work through their discussion of the services and programs offered by the Mission Department. What they shared about the Mission Department, although cloaked in vocabulary of racial colorblindness, reveals an ongoing racial project. This racial project reinforces existing cultural representations of Spanish-speaking settlers and relegates Spanish-speaking patients to outside the "mainstream" services offered by St. Peter's Seventon Health System.

Utilizing racial formation theory, this chapter explores the Mission Department at St. Peter's Seventon as a racial project. According to Omi and Winant (1994), the concept of racial formation captures the "sociohistorical process by which racial categories are created, inhabited, transformed and destroyed" (p. 55). The key assumption

behind this theory is race is a social and political construction that changes over time and is defined by historical struggles between racial groups over access to resources. Omi and Winant (1994) further submit, "society is suffused with racial projects, large and small, to which all are subjected. This racial 'subjection' is quintessentially ideological" (p. 60). On the one hand, existing understandings of racial groups are historically situated and change over space and time. On the other hand, these understandings also become an unquestionable part of our "common sense" notions of different race groups. Omi and Winant's racial formation theory highlights the interconnected processes of racialization, which occur on both the large-scale macro level and the micro-level through everyday interactions.

Race, like other social markers, ebbs and flows over space and time yet remains a categorical divider among groups of people. While shifting in context, race in the United States is a status to which all people are subjected. Rather than static, racialization processes are reflexive, relational, and contextual. Blumer (1958) defined race as a collective process completed in interaction within and among race groups. As discussed in Chapter IV, it is within these race groups that individuals map out racial boundaries and mark the color line between groups. Race as a social collective is constructed through an image of one's own race group in comparison to other groups. Individuals create an "us" racial group identity where ideas of group membership are linked to racialized bodies. Furthermore, racial groups are relational, hierarchical and cannot exist alone; they need each other as a point of reference, since the "us" cannot exist without the "them." Race is dynamic and a product of the interplay between the social structure and the actors, both at the individual and group level. An individual's ideas about race are merely

personal notions without the interaction and affirmation of others in a racialized social structure. As Berger and Luckmann (1966) suggest in The Social Construction of Reality, people are social products who, through social interaction, produce a social reality that, in turn, can create unequal structural consequences along racial lines.

Racial projects link cultural representations to the social structure in a reoccurring and reciprocal fashion. A racial project forms an "interconnected web" (Staiger 2004: 162) and its purpose is "simultaneously an interpretation, representation, or explanation of racial dynamics and an effort to organize and distribute resources along particular racial lines" (Omi and Winant 1994: 56). Racial projects are historically specific efforts that define the meaning and significance of race in ways that justify the particular allocation of rights, resources, and power.

For example, following the United States Naturalization Law of March 26, 1790, whiteness became associated with the rights to citizenship. The 1790 Naturalization Law provided the first regulation on citizenship access, privileging people of European descent and giving them full protection under the law. Two landmark Supreme Court decisions further embedded the differences between Whites and Non-Whites in the United States: Ozawa v. United States (1922)[i] and United States v. Thind (1923)[ii]. These two Supreme Court decisions highlight the racial project of whiteness through the distribution of resources, citizenship in these cases, along particular racial lines. Cultural representations of whiteness link to structural outcomes of citizenship and all its rewards and privileges. This active connection between the representations of Whites as citizens and citizens as beneficiaries of structural resources serves as a racial project because

racial dynamics are interpreted in an effort to organize structural resources along racial lines.

The emergence of Spanish-speaking settlers in new destination cities, places like Seventon, provide an opportunity to expose a contemporary racial project as the existing community reacts to the changing demographics. As described in Chapter III, some administrators within St. Peter's Health System relied on stereotypical representations of Spanish-speaking settlers. The ways administrators framed the system's response simultaneously violate the ideology of racial colorblindness and place settlers as outside the existing "mainstream" structure of health care services. Rather than integrate the needs of immigrants into the daily operations of patient care services throughout the hospitals, the administrators tended to relegate the concerns and needs of new settlers to the Mission Department. This chapter explores how administrators linked cultural representations of Spanish-speaking settlers to the Mission Department of St. Peter's Seventon Health System as an effort to distribute resources along racial lines.

THE RACIAL PROJECT OF SPANISH-SPEAKING SETTLERS

As explored in Chapter III, most administrators subscribed to the ideology of racial colorblindness. It is "common sense" to "not" see race, or at least to not admit to seeing race. However, while racial colorblindness is the dominant ideology, not all respondents strictly adhered to these norms. In conversations with health care administrators, racial stereotypes of Spanish-speaking settlers frequently emerged. Racial attitudes and norms shifted over time from Jim Crow racism to a newer, subtler form of racial prejudice, which cloaks stereotypical representations under the auspices of race neutrality.

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However, when emerging racial stereotypes are investigated further, racial attitudes can be easily linked to larger structural dimensions. As Omi and Winant (1994) state,

> The whole gamut of racial stereotypes – that 'white men can't jump,' that Asians can't dance, etc., etc. – all testify to the way a racialized social structure shapes racial experience and conditions meaning. Analysis of such stereotypes reveals that always present, already active link between our view of the social structure – its demography, its laws, its customs, its threats – and our condition of what race means (p. 59-60).

Our ability to understand the meaning of these racial stereotypes is predicated on existing understandings of the racialized social structure. Social structures are racialized as a result of the totality of social relations and practices that award racial privilege unequally. The dominant ideology of racial colorblindness reinforces unequal racial outcomes by submitting the social structure itself is race neutral since unequal structural problems were resolved with the Civil Rights Movement. Despite claims that racial attitudes have ameliorated over time, as indicated by the shift from overt, Jim Crow style racism to a covert, racial colorblindness, the process of linking cultural representations of race to a racialized social structure still occurs within the dominant ideology of racial colorblindness. Racial colorblindness helps mask the stereotypical representations as common sense rather than prejudiced. Additionally, the ideology of racial colorblindness may prevent awareness of racial prejudices and convince people they actually do not see race.

Racial projects form an interconnected web between cultural representations and the racialized social structure. Within St. Peter's Seventon Health System, the Mission Department serves to link ideas about Spanish-speaking immigrants as indigent and "illegal" to mission-related services accessed outside the mainstream care offered by the health care system. Administrators eschewed responsibility for both knowledge of and

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job-related responsibility for Spanish-speaking patients by diverting their needs toward the Mission Department rather than embracing them as part of the overall services offered by St. Peter's Seventon or as part of their departmental or facility's operations. Of the 132 daily admissions across all St. Peter's Seventon Health System hospitals, approximately 8 are foreign-born and 5 are Latinos. While administrators defer Spanish-speaking patients to outreach services, many require in-patient hospital care. Although both the foreign-born and Latino populations are relatively small compared to the White and Black populations, both grew faster than state and national averages over the last ten years. Thus, Spanish-speaking patients are not an infrequent occurrence but a growing demographic of patients seeking services across the care continuum. St. Peter's Seventon Health System administrators must wrestle with integrating this new patient population into existing (not just hospital) services rather than reproduce representations of this group as only accessing outreach services.

ST. PETER'S SEVENTON – ON A MISSION TO SERVE

Catholic hospitals have at least three distinguishing features: they are not-for-profit, ecclesial, and, as part of the Catholic Church, extend a mission to serve the poor and marginalized. According to White (2000), Catholic health care began "primarily as a social welfare ministry in response to urban need" (p. 215). White further argues discrimination faced by poor Irish Catholics likely compelled the creation of these separate religiously based hospitals to serve socially marginalized groups (2000: 217). From this original vision, Catholic health care has become one of the leading not-for-profit health care providers in the United States while still espousing the mission of serving those in need. Catholic hospitals adhere to the *Ethical and Religious Directives*

for Catholic Health Care Services to guide their health care ministry. The *Directives,* written by the United States Conference on Catholic Bishops, provide a theological basis for Catholic health care services. Mission Departments ensure local Catholic health care systems fulfill the Catholic Church's vision of health care and abide by the *Directives*. These *Directives* extend five principles: a commitment to "promote and defend human dignity," "care for the poor," "contribute to the common good," "responsible stewardship of available health care resources," and to "refus[e] to provide or permit medical procedures that are judged morally wrong" (United States Conference of Catholic Bishops 2001). Stempsey (2001) suggests hospitals show their "fidelity" to the Catholic Church through patient care, commitment to the "medical-moral issue," and through its "prophetic role" through service to the indigent (p. 5). Most administrators express a connection to the mission as part of what they value about their job, the organization, or as a distinguishing feature of the health care system. For example, Anna Windel, an upper management administrator for St. Peter's Seventon Health System, said of St. Peter's,

> This is probably Catholic health care at its best. I thought I worked in Catholic health care before but this is so much more mission based than anything I had experienced… it's just really cool for me. There's a whole other aspect of, I guess, job satisfaction and of fulfillment that I hadn't expected. It was definitely a bonus. Wasn't looking for it, didn't know it was missing.

Anna's experience was typical of administrators, particularly those who were administrators in other hospitals prior to joining St. Peter's Seventon Health System and those who expressed a connection between their work and spiritual lives. Leah Reeves, a middle management administrator at St. Michael's Medical Center, echoes Anna when she says,

I was surprised and pleased when I started working here. I think the mission is really very, very important. I mean, companies, hospitals, health care systems have their mission, their vision, their values and you post them on the wall. And I really do believe that we strive every day to be who we say we are. And I have not heard otherwise from the administration.

Although most administrators are not Catholic, nearly all describe a personal connection to the mission of St. Peter's Seventon and the Catholic Church, particularly around the quality of patient care and as an element of administrative decisions. Most administrators spoke of the mission of the health care system as an extension of the Catholic Church in a general sense.

In addition to their personal connection to the mission and values the Catholic Church, some administrators connected the Catholic mission as a driver for Spanish-speaking care at St. Peter's Seventon Health System. For example, when asked about how St. Peter's Seventon was adapting to the changing community, Barbara Sanders, a middle management administrator for all of St. Peter's Seventon Health System, said, "It's the whole mission of serving the underserved. And, unfortunately in our country, a lot of the underserved are the diverse groups and I think that's part of the mission of this organization." Other administrators, like Andy Darling, an upper management administrator for all of St. Peter's Seventon Health System, similarly connected contemporary demographic changes to the mission of the hospital as an extension of the Catholic Church. He expresses a connection from the historical creation of Catholic hospitals as serving the marginalized to attending to the needs of the Spanish-speaking community today.

It's on the radar for St. Peter's Seventon for religious reasons and Mission reasons. Mission reasons because I believe, I'll just say… I'll talk from this… they are seeing more of them in the communities that the MobileMed is touching. Fair? From religious reasons, we're trying to respond to a trend that identifies the

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Catholic Church as a southern hemisphere faith and responding to the needs of Catholics coming into the community. As much as the Catholic Church has responded to Italians and Irish at the turn of the century, they're responding to Hispanics now. We need to do that.

Many of the administrators who expressed connections to the Catholic mission of the organization paradoxically also deferred responsibility for perceived cultural needs to the Mission Department. The connection seemed more enjoyable in abstraction rather than as part of one's daily milieu.

The Mission Department at St. Peter's Seventon Health System is a large department with administrators serving in each of the four hospitals and across the entire system. This department is responsible for sponsorships, ethical consultations, spiritual care, and various community health programs. Most related, the Mission Department houses the mobile medical unit, liaison for Hispanic health, and cultural diversity committee. Concretely, the Mission Department serves both patients and the community through a variety of initiatives. Publically, this department is the front-line for hospital sponsorships and charitable outreach programs. Typical sponsorships include contributing toward community awareness and fundraising walks, local non-profit galas, and United Way campaigns. Charitable outreach programs are generally more direct-patient programs and community health initiatives. Programs include mobile medical units, childhood immunization drives, and health education programs. Within the hospitals, the Mission Department serves patients through spiritual care delivery in patient rooms and in the hospital chapel, and through ethical review boards. These review boards evaluate clinical and administrative processes according to the mission of the Catholic Church and in adherence to the *Directives*. The responsibilities of the Mission Department extend far beyond one particular group of people and charitable care.

Despite administrators' expressed connection to the Catholic mission and feelings of being "called to serve," most referred Spanish-speaking patients' needs to the Mission Department rather than as part of their personal job responsibilities or daily operations of the overall health care system. By placing Spanish-speaking patients' needs as outside St. Peter's Seventon's "mainstream" services, administrators both reinforce representations of Spanish-speaking patients as charitable care and justify allocating Spanish resources to outreach programs.

PIMP THE MISSION, PUSH THE MARGIN

Most administrators at St. Peter's Seventon embraced the Catholic identity and mission as part of their job and the system's identity, yet some doubted the executive leadership's sincerity in meeting the Church's call. Many also questioned the mission's role in the system's daily operations. The executive leadership guides the entire health system in accordance with the *Directives*. The executive leadership is also responsible for ensuring the health care system's success, especially guaranteeing profit to reinvest. Nelson Jordan, an upper management administrator at St. Josephine's Medical Center, represents one of a few administrators at each hospital who occupy a dual role of medical provider and administrator. When asked why he practices medicine at St. Josephine's, he responded in alignment with previous administrators,

> I think their mission is a very noble mission. It's very noble mission. I think that one of the things about the medical staff here, and that says a lot, is that the guys here… because of our backgrounds… many of us choose to practice here because we actually believe in the mission. So, I don't think you can… I mean, Jesus said have all the children to come unto me. You have to take care of everybody.

Despite not being Catholic, he felt connected to the hospital's overall mission and religious connection. Nelson, however, questioned the executive leadership's adherence to St. Peter's Seventon's mission, beyond just the hospital he served.

> I think the challenge for St. Peter's Seventon is that they pimp the people for the mission when their heart is in the west end and St. Elizabeth's. You know? …. The demographic that pays the most. And trust me, I mean, *if there's no margin, there's no mission*. You know what I mean? But I also know that Jesus took 5 fishes and fed 14,000 people, probably 10,000, at least. Because he fed 5,000 in the Bible but he didn't talk about the women. They just counted the men. You know what I mean? If you go to church, like I go, there's more women than men. You know what I mean?

Nelson understands the relationship between the pursuit of profits and the health care system's mission: the system cannot work toward the mission without financial backing. However, he questioned whether mission-related outreach was simply for display rather than a true calling. Both St. Elizabeth's and the "west end" represent predominantly White, affluent areas of Seventon and both stand in stark contrast to the daily experiences Nelson faces at St. Josephine's. Nelson's frustration was understandable. The executive leadership of St. Josephine's is shared with St. George's and all are located at St. George's. During my summer in Seventon, St. Josephine's administration complained about unfulfilled routine maintenance requests. St. Josephine's is the historically Black hospital and is an older hospital facing many challenges of an older building. Yet, St. Josephine's stood in stark contrast to the system's other facilities, which were either new or continuously updated. Nelson's observations suggest the executive leaders "pimped" St. Josephine's as the mission hospital in order to pursue the margin in the predominantly White, affluent areas.

Nelson was not alone in his concerns for the marginalization of the overall Catholic mission. According to Nash Finnagan, an upper management administrator for

all of St. Peter's Seventon Health System, the "real core mission to serving the dying and the poor gets buried unless you're… But it's like … no margin, no mission." Nash, like Nelson, believes St. Peter's Seventon's mission is to serve all people in need. Yet, he also expressed the mission is impossible without the financial backing to support programs. Nash continues to suggest ways to promote particular mission-related programs, such as a pediatric hospice and palliative care program, in order to garner community donations. When asked if he could develop community donations around the mobile medical unit he said,

> It allows me to talk about the mission of [St. Peter's Seventon] to people who are motivated by taking care of the underserved and health care disparities, but I haven't found a lot of passion among my donors for supporting us for helping the underserved.

The mission, according to Nash, is a commodity to sell to potential donors in abstraction yet not a concrete goal to solicit contributions.

Finally, Mission Department administrators also expressed frustration with the perceived marginalization of their department. When asked about diversity committee successes, Kathleen Vess, a middle management administrator for all of St. Peter's Seventon Health System, says,

> Well, we do celebrations around events. We try to make people aware when something is going on, even in the community, that's related. And, we try to attend these things as much as we can. So, we're involved with the Hispanic Chamber of Commerce. We're involved with the Asian Chamber of Commerce pretty significantly. And, our office tries to be a liaison to make sure that St. Peter's Seventon is sponsoring these organizations. That's the one way that Marketing and I kind of work together. Because, I think, again, I don't know if it's resistance, it's just awareness raising. I just think a lot of education still has to be done. St. Peter's Seventon has sponsored a lot of things and until more recently… I think it's beginning to happen more, something that might be like a Black history event or Hispanic event. It's like… oh, Mission will do that. That's what I mean when I say… it's sort of marginalized yet.

Kathleen's comments reflect Nelson and Nash's suggestions that St. Peter's Seventon's mission is marginalized. Particular people are expected to carry out the mission for the entire system rather than focusing on the mission as an incorporated strategy across all hospitals and departments. Kathleen's concern is that community sponsorships go unrecognized and the Mission Department is continuously saddled with additional sponsorships and responsibilities. Kathleen's comments also imply the marginalization of mission-related activities as a result of sponsorships linked to communities of color.

Nelson, Nash, and Kathleen all point to the marginalization of the Catholic mission and the Mission Department within St. Peter's Seventon Health System. Nelson expresses concern for what he perceives as the "pimping" of the mission in order to develop and sustain programs for the White, affluent members of the Seventon community. Nash, on the other hand, openly suggests the mission in abstraction works to generate donations but he cannot garner support for donations of concrete programs. Finally, Kathleen puts forward the Mission Department is marginalized within St. Peter's Seventon. These three administrators describe the Mission Department as outside the system's mainstream activities and suggest the mission is not an integrated strategy but is marginalized among the executive leadership and donors.

SPANISH-SPEAKING PATIENTS: OUTSIDE THE MAINSTREAM

When asked how they viewed Spanish-speaking patients impacting the health care system, most administrators assumed a stance of colorblindness and suggested they had not noticed a demographic change in patients. As discussed, many relied on universalisms, such as "a patient is a patient," to shift conversations away from race-cognizance toward general statements about care for "all" people. However,

administrators did discuss services for Spanish-speaking patients as outside the

"mainstream" services. Consistent with racial colorblindness frames, administrators

projected their own innocence while relying on a "Mission knows best" position.

Administrators deferred all potentially culturally related issues to a particular Mission

Department employee or to the Department more generally. Additionally, administrators

discussed Spanish-speaking patients' utilization of Mission Department outreach services

or programs as patients embedded within the system's overall services.

Mission Knows Best

Administrators suggesting they did not know how the changing demographics

impacted their hospital or the healthcare system often referred me to the Mission

Department or to specific administrators within Mission. As a matrix organization, all

administrators are responsible for substantive information outside their home department.

By shifting the conversation and responsibility to the Mission Department, administrators

project both their own innocence and suggest Spanish-speaking patients' needs fall

outside the health care system's mainstream services. For example, when asked if she

ever received national system office information about Spanish-speaking patients' needs,

Allison Young, an upper management administrator at St. Elizabeth's Medical Center,

says,

> I feel bad about saying it. I know they do have a focus and they have a person that
> works with it. I think our interaction has been fairly minimal. I'm really not sure
> what the strategy is, but it may come through Mission and then I'm getting it fed
> through Patty. And, it may come down through Mission and then go out, which
> sounds appropriate to me. It wouldn't come through me necessarily.

Allison's statement marked Spanish-speaking patients as beyond her direct

responsibilities and as information she would get from Patty, a Mission Department

middle management administrator. Despite being one of St. Peter's Seventon's top administrators, Allison did not know of a system-wide integrated strategy for Spanish-speaking patients. Daniel Huffman, another upper management administrator for St. Michael's Medical Center, similarly suggested Spanish-speaking patients' needs fall outside the system's mainstream services, especially outside St. Michael's, the flagship hospital.

> If I was an administrator in a stand-alone hospital in the middle of the city, I'd probably be doing more advocacy for change or more advocacy for support for the Hispanic population, if that's what is around the hospital. If you went to some of the St. Peter's hospitals in different parts of the country that are more in the city… even St. Josephine's, you might see more advocacy than what we do here. I think probably we'd be challenged by St. Peter's and maybe Catholic Health Association. Why aren't we doing more at our level versus just Mission doing the stuff? And of course… how many hours in the day and all that stuff? That's one reason we got Mission. We got a lot of people in there that can help do that.

Both Allison and Daniel shift concerns for Spanish-speaking patients from their own responsibility, or the responsibility of the hospital they oversee, onto the Mission Department that serves the entire St. Peter's Seventon Health System. The shift in responsibility not only protects their own innocence but also highlights Spanish-speaking patients as pushed to the system's margins. There is, after all, a dedicated staff within the Mission Department to work toward those issues. By deflecting responsibility for both knowing about Spanish-speaking patients and for advocating on their behalf onto the Mission Department, administrators reinforce the racial project of Spanish-speaking patients as charitable care. The representation is Spanish-speaking patients seek services outside the mainstream health care services and the Mission Department developed the strategy for meeting those needs. The system is stuck in an organizational rut where

services to Spanish-speaking patients are viewed as medical outreach organized by the Mission Department.

Serving Spanish-speaking Patients on the Outside

When discussing Spanish-speaking patients, some administrators quickly discussed the use of mobile medical units, the care card program, and other outreach services. Although these programs are available to any patient who either does not have medical insurance or is in financial need, some administrators discussed only the propensity of Spanish-speaking patients to utilize these services. By equating outreach programs with the Spanish-speaking community, administrators reinforce the racial project of Spanish-speaking patients as charitable care and in need of Mission's services. The racial project links the representation of Spanish-speaking patients as needy and relegation of Spanish-speaking patients beyond the system's main activities. For example, Ellen Procoppio, an upper management administrator for all of St. Peter's Seventon Health System, replied to queries on the hospital's response to the rise in Spanish-speaking settlers by saying,

> We have a good size population of Spanish, but it's not in the hospitals because they're afraid to come to the hospitals. And that's why the MobileMed is so successful in those areas. And you're not going to see that in the Black population 'cause they know they can come and get treatment and they wouldn't hesitate to do that at one of our hospitals. But, I know for a fact that the Spanish are nervous because I've heard of women with large cancerous lumps in their breasts and they're afraid to come and get treatment.

Ellen's statement quickly provides several assumptions about the Spanish-speaking community. First, they are undocumented and utilize health care differently from other racial groups, even other groups of color. Second, she links these representations with understandings of how Spanish-speaking patients access health care services, notably not

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using the hospitals but receiving treatment from the mobile medical unit. Ellen presents a

medically daunting situation: people delaying treatment as a result of fear. When asked

what the hospital did for this particular woman, Ellen continued,

> Well, do you know Sister Mary Catherine? She's the one who promised this
> particular woman, 'Don't worry about it. I'm a sister.' You know… it's a big deal
> with the Spanish… the Catholic. 'Nothing will happen to you, no one is going to
> hassle you.' So, the woman finally came to get treated. It's sinful…. Some people
> just don't believe in hospitals.

Again, Ellen's representation centered around this woman's fear of utilizing the health

care system because something might happen to her, presumably deportation. Despite the

representation of this woman as seemingly undocumented, Ellen then shifts the

discussion into how "some people just don't believe in hospitals." She represents the

Spanish-speaking community as living outside the mainstream in terms of citizenship

status. She then links this representation to assumptions about marginalized health care

access, such as mobile medical units. Ellen seems to conflate the woman's fear with her

beliefs about medical access. Although this woman might be fearful of jeopardizing her

security of place, according to Ellen it is her underlying disbelief in hospitals that

prevents her from accessing care.

Donna Neal, a middle management administrator at St. Michael's Medical Center,

also connects cultural representations of Spanish-speaking settlers to the system's

mission to serve this population outside the mainstream services offered. Donna says,

> I think that especially in the emergency department, we see a lot of the Spanish-
> speaking population and it's funny. You know, 'cause I manage that area as well,
> but you don't see those patients scheduled for surgery. I don't see that same
> volume of patients coming in for surgery. With respect to African-American and
> Caucasian. I don't think it's too far to think it's about 50/50 population. I don't
> even think it's 60/40, I truly think it's a 50/50 mix. You really don't see a lot of
> Spanish-speaking. Whether it's Puerto Rican, you don't see it and I think what
> helps that is the MobileMed. We offer services to the community like that, so it's

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part of our branding of good help… You know? We have the Care Card Program, where patients who either don't have insurance or who are under-insured, we offer that financial assistance, and we advertise that and so it's not like once they get in the door and we realize they can't pay that we say, 'Oh no, we can't assist you with this.' No, that's part of our mission."

Unlike the administrators earlier who eschew responsibility for Spanish-speaking patients, Donna actively discusses their absence in the areas she supervises. Not only does Donna frame Spanish-speaking patients as using the mobile medical unit, she also directly links them to another mission-related program, the Care Card Program. The Care Card Program is offered to all under or uninsured patients, yet Donna actively links the program with Spanish-speaking patients. Like Ellen, Donna also distinguishes the Spanish-speaking patients from the Black and White patients at St. Peter's Seventon. While Donna's suggestion that all people utilize the emergency room stands in stark contrast to Ellen's comment, both highlight the use of services outside the main hospital structure. These descriptions link representations of Spanish-speaking patients as indigent, potentially undocumented, and as consuming additional resources to outreach programs and services, such as the mobile medical unit. The result of this representation is services available for Spanish-speaking patients are viewed as appropriate for outside the main hospital rather than as integrated in the overall care delivery. Once these programs are established and subsequently utilized, the utilization trends reinforce the cultural representations. Connecting programs and services offered by the Mission Department to Spanish-speaking settlers, while absolving administrators of responsibility, creates a circular argument about who immigrants are and what services they need.

By relegating Spanish-speaking patients to a siloed department and marginalized programs, St. Peter's Seventon Health System finds itself stuck in an organizational rut, viewing Spanish-speaking patients as users of mission-related activities and failing to integrate these patients' needs into the hospital's main services. As a result, administrators only see Spanish-speaking patients as outside the margins because this is the only place where strategies were developed. The racial project of viewing Spanish-speaking patients as needy becomes a self-perpetuating cycle where existing representations are reinforced by structural outcomes, chiefly utilization of mission-related programs. Ultimately the cultural representation of Spanish-speaking patients as indigent and undocumented results in organizing the system's resources along racial lines such that questions about Spanish-speaking patients automatically generate mission-related responses.

If St. Peters Seventon Health System received a direct proportion of Seventon's foreign-born and Latino population, then approximately six percent of the daily admissions would be foreign-born and approximately four percent would be Latino. This would amount to 5 Latino and 8 foreign-born patients in the 132 daily admissions across the system. The Seventon Latino population is far smaller than the White (60 percent) and Black (30 percent) populations. However, the Latino population is experiencing rapid growth and is currently the third largest racial/ethnic group. Administrators view the population of Spanish-speaking patients as small enough to reasonably shift programs to the Mission Department. However, demand for services continues to grow in tandem with population growth. Administrators identified drastic increases in Mobilemed

utilization. This increase resulted in the addition of a second unit within five years and plans to secure funds for a third unit. Deferring Spanish-speaking patients to the Mission Department reinforces notions of Spanish-speaking patients as recipients of charitable care and as a homogenous group of patients. Where is the "tipping point" when St. Peter's Seventon Health System moves Spanish-speaking patient services from the margins to the mainstream? When would the demand reach a level to warrant institutional change and full integration?

[i] Takao Ozawa's petition for naturalization reached the Supreme Court in 1922. Ozawa, a Japanese immigrant, argued that people of Japanese descent were of the White race and therefore should have access to naturalization. The Supreme Court ruled that only Caucasians were White and Japanese were not Caucasian. This decision excluded Ozawa from whiteness and subsequently made him ineligible for naturalization. The racial state contended that Ozawa was not Caucasian and Caucasians were the only Whites. Thus, whiteness was the deciding factor in naturalization, particularly since all other races were assumed to be inassimilable. Ozawa's petition did not challenge restrictions around naturalization but argued that Japanese were White. This early Supreme Court ruling derived from the pseudo-scientific understandings of race.

[ii] Learning from Ozawa's case, in 1923 Bhagat Singh Thind petitioned the Court for naturalization with the understanding that as an immigrant of Asian Indian ancestry he was Aryan. As an Aryan, he was Caucasian by the Court's "scientific reasoning" and therefore eligible for citizenship. The Supreme Court denied Thind's petition, not based on the scientific understanding of race used in Ozawa's case but based on a common layman's understandings of whiteness, which excludes Asian Indians. Therefore, the Court denied Thind access to naturalization based on a common understanding of whiteness while a year prior Ozawa was equally denied access but based on scientific "reasoning."

CHAPTER VI

ROOTED IN THE PAST, BLIND TO THE PRESENT: IMPLICATIONS

OF COLORBLINDNESS, RACIAL HIERARCHIES, AND RACIAL

PROJECTS

Seventon is experiencing tremendous demographic change, yet is deeply rooted in the past and prides itself on its contributions to U.S. history. The city is marked by historical reminders from monuments commemorating Confederate soldiers to mall kiosks detailing the city's history. While deeply embedded in its past, Seventon also struggles to distinguish itself as a modern cosmopolitan, desirous of Fortune 500 companies and new residents. New Spanish-speaking settlers arriving in Seventon experience a community struggling between a racial legacy and contemporary vision. The goal of this study was to discover how health care administrators embedded in a new destination city, one concerned with representing the past and moving into the future, respond to the growth of Spanish-speaking settlers. Additionally, I sought to complicate existing understandings of how people discuss newly settled immigrant groups in an era of racial colorblindness.

Spanish-speaking settlers are arriving in communities across the United States, many of which were not previously considered immigration destinations. The existing communities, and their new members, find organizations and services ill-equipped to deal with the changing demographics. Seventon represents both the demographic changes and challenges in community response and adaptation. Seventon experienced a 150 percent growth in its foreign-born population between 1980-2000, far above the national average of 121 percent. The Latino population grew 230 percent over the same time period, also

vastly exceeding the national average of 142 percent. Currently, the foreign-born population represents six percent of Seventon's population and the Latino population accounts for four percent. While both are relatively small compared to the White (60 percent) and Black (30 percent) populations, they have each experienced tremendous growth over the last 20 years. Seventon is a prime example of rapid demographic change in an unexpected place.

Health care facilities are sites, like schools and other resources, where existing community members and Spanish-speaking settlers meet. Health care facilities are also locations where people go when they are at their most vulnerable and in need of care. How administrators identify their role and response to a new patient population base has serious consequences for the well-being of this group. If administrators do not see a need for additional resources, the quality of care for this subset of patients is diminished. Administrative decisions have real-life consequences for patient outcomes across the care continuum.

RACIAL COLORBLINDNESS

The dominant racial ideology in the United States is racial colorblindness. This ideology suggests obstacles for people of color were removed following the Civil Rights movement and any lingering effects of racism would cease if people simply stopped talking about race. Put simply, colorblindness asks people to stop seeing race. One consequence of this ideology is a general fear of discussing race, leading to the idea that if one talks about race, one may be perceived as complicit in perpetuating racial inequalities.

Health care administrators, like many in the United States, do not know how to talk about race. The dominant ideology prohibits meaningful conversations about how race influences people's lives. As a result, people seek to ignore the ways race is embedded in larger structural arrangements, such as health care services and opportunities. St. Peter's Seventon Health System administrators reinforced the dominance of racial colorblindness through their responses to questions about Spanish-speaking patients. I found three colorblind frames: universalisms, minimization, and frames of innocence.

First, the frame of universalisms served to ignore Spanish-speaking patients' needs and mask them under the umbrella of "all patients." By viewing a "patient as a patient," administrators reinforce the ideology of race neutrality and gloss over potentially culturally sensitive issues.

Second, the frame of minimization served to quickly dismiss the needs of Spanish-speaking patients and end the conversation. By suggesting they "don't see race" or they have "no need to segment off" racial groups, administrators quickly framed themselves as colorblind. If they do not see race, they cannot discuss how it impacts in the hospital.

Third, administrators used four sub-frames of innocence to flag themselves as free from racial bias: beyond the job description, denial, personal progress, and naivety. Frames of innocence, by marking information as beyond their job description, placed information out of reach to administrator's knowledge while maintaining their position as colorblind. The frame of denial was used by administrators in response to demographic changes in the community. By not noticing the demographic changes in the community,

administrators could not incorporate that knowledge into their professional decisions. Administrators also used stories of personal progress as a colorblind frame of innocence. These frames often recounted stories from previous generations, like parents or grandparents, to express how far their personal racial views have developed. Additionally, administrators relayed stories of their children's racial progress, either through diverse friend networks or by discussing their child's interracial dating. Finally, administrators framed their innocence through their naivety about racial issues. Often this frame emerged as administrators relayed their surprise to race-related stories from a person of color. These narratives regularly included statements like, "my Black friend told me this," which mark the administrator as innocent in these interactions.

In addition to the frames of racial colorblindness, some administrators also relied on racial euphemisms to talk about race groups. These racially coded words allowed administrators to talk about race without directly mentioning racial groups. Euphemisms included discussion of real race groups through coded language, such as "urban," and descriptions of imaginary race groups, such as "yellow with green dots."

The frames of racial colorblindness all reinforce the dominant ideology of racial colorblindness in ways that perpetuate the existing structural arrangements in Seventon. The dominant ideology of racial colorblindness encourages administrators to ignore Seventon's changing demographics. As a result, St. Peter's Seventon Health System's existing services do not reflect the changing demographics. This disconnect ultimately impacts the overall quality of care Spanish-speaking patients receive as patients receive care in Spanish primarily through outreach programs, translator phones, or poorly staffed bilingual providers rather than routinely through the system's primary services. The

ideology of racial colorblindness also reinforces existing racial hierarchies and pushes Spanish-speaking patients outside the mainstream services offered by St. Peter's Seventon and into the margins of the health care system.

St. Peter's Seventon Health System administrators are restricted by the ideology of colorblindness both nationally and locally. If administrators overtly discuss racial matters, they violate the norms of racial colorblindness and risk being perceived as racist. If they ignore race and subscribe to norms of racial colorblindness, they reinforce racial inequalities and diminish the quality of care for a subset of patients. Administrators must also balance existing financial and human resources. Thus, administrators are stuck in a professionally high stakes bind with no obvious solution. Administrators were not overtly racists but struggled to know how and when to meaningfully talk about race, reflecting the dominance of racial colorblindness.

RACIAL HIERARCHIES AND THE COLOR LINE

In 1903, W.E.B. DuBois stated that the problem of the 20th century was the problem of the color line. DuBois' enduring remarks continue to highlight racial differences in access to resources and services. Rather than debating its existence, contemporary debates challenge the location of the color line as a White/Non-White line, Black/Non-Black line, or triracialized system. As I have shown, all of these theories provide valuable insights, yet none perfectly align with St. Peter's Seventon administrators' perceptions. Each of these three theories suggests a simple division between race groups, in terms of either a binary or ternary division. Additionally, most of these theories rely on "objective" indicators, such as income, home ownership, or educational attainment. St. Peter's Seventon administrators' views most closely aligned

with Bonilla-Silva's triracialized stratification system. However, administrators' views were far more complicated than a three-tiered system might suggest. Administrators' understandings were strongly influenced by the dominant ideology of racial colorblindness, as seen by the general tentativeness to discuss race or potentially culturally sensitive issues at work. However, when conversations shifted away from work to more personal settings, such as neighborhoods, schools, or local grocery store, administrators were far more willing to discuss changing demographics. Administrators who did not see demographic changes or reluctantly discussed changes within the hospitals shifted to openly highlighting changes throughout Seventon. Most administrators racially mapped Seventon, stressing where different racial groupings lived relative to their own home. These personal racial geographies are not included in existing theoretical understandings of color line, and certainly not in objective indicators. I was only able to capture this type of understanding by asking administrators to compare and contrast their professional and personal lives. Existing theoretical understandings fail to address the more complicated ways people see race every day.

PIMP THE MISSION

The one area of work where most administrators freely discussed Spanish-speaking patients was in connection to the Mission Department. I argue the nearly automatic linkage of Spanish-speaking patients to the mission of the Catholic Church and Mission Department of St. Peter's Seventon Health System serves as a racial project. The overall mission of St. Peter's Seventon as a Catholic hospital is to serve as an extension of the Catholic Church in its ministry of providing health care. Most administrators describe a personal connection to the mission of the organization, notably as a strong

component of their overall job satisfaction. Yet while administrators quickly described an affinity for the mission of St. Peter's Seventon, most eschewed responsibility for integrating the mission into their daily responsibilities or system operations. Rather than integrating the needs of Spanish-speaking patients into their daily operations, administrators deferred responsibility to the Mission Department. By linking the needs of Spanish-speaking patients to the Mission Department, administrators reinforce cultural representations of this particular group as indigent and outside the mainstream services offered by the health care system. This active racial project is "simultaneously an interpretation, representation, or explanation of racial dynamics and an effort to organize and distribute resources along particular racial lines (Omi and Winant 1994: 56). Administrators interpret Spanish-speaking patients as outside the mainstream and subsequently relegate services to this community primarily outside the hospital walls. Consequently, Spanish-speaking patients continue to access services through community outreach programs, where they are readily available. The representation of Spanish-speaking patients as indigent reinforces racial dynamics reciprocally.

The dominant ideology of racial colorblindness likely contributes to this racial project. Colorblindness requires administrators to ignore race, particularly at work. However, I found when conversations shifted outside their professional lives administrators openly discussed racial changes and racial geographies. The stakes involved in discussing race, particularly in light of the dominance of racial colorblindness and the embedded Black/White history of Seventon, challenge any administrator from integrating Spanish-speaking needs. However, racial colorblindness masks the distinctions administrators actively make. Administrators more willingly identify

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Spanish-speaking patients' needs as an extension of the Catholic mission likely as a result of their distance from the services provided. However, by relegating Spanish-speaking patients' needs to outreach programs of the Mission Department, administrators are structurally placing a subset of patients outside the main hospital services and reinforcing hierarchies of difference. Administrators wrestle with locating the "tipping point" when Spanish-speaking patients are no longer viewed as a subset of outreach patients.

IMPLICATIONS AND FUTURE CONSIDERATIONS

As Spanish-speaking settlers arrive in new destinations across the country, surrounding communities are changing and adapting. Seventon provides a window into how administrators in one such community frame their institution's role and response to those demographic changes. Embedded within a history of racial tension, the community of Seventon has begun to disrupt its rigid racial understandings and hierarchies to incorporate the growing Spanish-speaking community. St. Peter's Seventon Health System provides an opportunity to examine these changes in a site, and at a time, when existing and new communities are integrating.

The story of Seventon and St. Peter's Seventon Health System is a story of a community in transition. Administrators, like most of the United States, do not know how to talk about race, even when talking about race is necessary to open access to all community members. Administrators also seem bound by existing understandings of race relations and struggle to know how to adjust services and access to incorporate new groups. W.E.B. DuBois suggested the problem of the 20th century was the problem of the color line. In Seventon the contemporary problem is seemingly the problem of color

lines. Existing health care services in St. Peter's Seventon must adapt to Spanish-speaking settlers if patient quality of care is going to be equitable.

In his aptly named book, *The Tipping Point,* Gladwell (2000) suggests phenomena require a contagious spread of behavior, change in a few areas, and rapid change for the tipping point to occur. While Seventon is rapidly experiencing demographic change, St. Peter's Seventon Health System remains stuck in an existing business mindset. Administrators undoubtedly face numerous obstacles as they work through the demographic changes. The contemporary ideology of colorblindness restricts them from meaningful discussions about race without significant professional, and perhaps personal, risks. Administrators are located in a town where existing racial hierarchies were relatively stable yet are suddenly beginning to be disrupted. They are also in a town characterized by a deeply embedded racial history and marked by contemporary racial tensions. Thus, administrators walk through a minefield of conflicts with no clear map to safety. Fortunately, administrators can rely on the mission of St. Peter's Seventon Health System and Catholic hospitals, in general, to guide their path. As noted by a few administrators, Catholic hospitals originated, in part, to serve the socially marginalized. Seventon's demographic changes mark an opportunity for St. Peter's Seventon Health System, as a Catholic hospital, to rise to this moment again. As it currently operates, St. Peter's Seventon is not meeting the needs of a subset of its patients. Yet, the mission and values of the Catholic Church provides them with a unique opportunity to challenge existing understandings and integrate services.

The mission and values of the Catholic Church suggest the "tipping point" has arrived for health care administrators to shift from viewing Spanish-speaking patients as

outreach and charitable care patients to mainstream patients who routinely receive care inside the hospital walls. Concretely, administrators should invest in culturally competent programs to train all direct and indirect care providers with the tools and resources to meet the changing demographics. Rather than isolating services to the Mission Department or its outreach programs, Spanish-speaking patients should be integrated into the overall flow of information typical of matrix organizations. Thus, the onus is on every administrator, physician, nurse, and staff member to provide good help to all in need. If history provides a hopeful lens to the future, Catholic hospitals are well suited to meet the growing needs of Spanish-speaking patients.

REFERENCES CITED

Adorno, Theodor W., Else Frenkel-Brunswik, and Daniel J. Levinson. 1950. *The Authoritarian Personality*. New York: Harper.

Allison, Matthew A., Matthew J. Budoff, Nathan D. Wong, Roger S. Blumenthal, Pamela J. Schreiner, and Michael H. Criqui. 2008. "Prevalence of and Risk Factors for Subclinical Cardiovascular Disease in Selected US Hispanic Ethnic Groups: The Multi-Ethnic Study of Atherosclerosis." *American Journal of Epidemiology*. 167(8): 962-969.

Allport, Gordon. 1958. *The Nature of Prejudice*. Garden City: Doubleday.

American Hospital Association. 2006. "Beyond Health Care: The Economic Contributions of Hospitals." Washington, DC: American Hospital Association.

American Hospital Association. 2007. "Trendwatch Chartbook 2007." Washington, DC: American Hospital Association.

Andalo, Paula. 2004. "Health for One and All: Latinos in the USA." *Perspectives in Health*. 9(1). Retrieved April 24, 2011. (http://www.paho.org/english/dd/pin/Number19_index.htm).

Andrulis, Dennis P. and Lisa M. Duchon. 2005. "Hospital Care in the 100 Largest Cities and Their Suburbs, 1996-2002: Implications for the Future of the Hospital Safety Net in Metropolitan American." Princeton: Robert Wood Johnson Foundation. Retrieved April 24, 2011. (http://www.rwjf.org/files/research/Andrulis%20Hospitals%20Report-final.pdf)

Antecol, Heather and Kelly Bedard. 2006. "Unhealthy Assimilation: Why Do Immigrants Converge to American Health Status Levels?" *Demography* 43(2): 337-360.

Archibold, Randal. 2010. "Arizona Enacts Stringent Law on Immigrants." *New York Times*, April 23. Retrieved May 26, 2011 (http://www.nytimes.com/2010/04/24/us/politics/24immig.html?ref=randalcarchibold).

Bachmeier, James D. 2007. "New Destination 'Context of Reception': Coethnic Concentration and Earnings of Mexican Immigrants." Presented at the annual meeting of the Population Association of America, March 30, New York, NY.

Bean, Frank D., Rodolfo Corona, Rodolfo Tuiran, Karen A. Woodrow-Lafield, and Jennifer Van Hook. 2001. "Circular, Invisible, and Ambiguous Migrants: Components of Difference in Estimates of the Number of Unauthorized Mexican Migrants in the United States." *Demography* 38(3): 411-422.

Bender, Deborah E., Margaret Clawson, Christina Harlan, and Rebecca Lopez. 2004. "Improving Access for Latino Immigrants: Evaluation of Language Training Adapted to the Needs of Health Professionals." *Journal of Immigrant Health* 6(4): 197-209.

Berger, Peter. L., and Thomas Luckmann. 1966. The Social Construction of Reality. New York: Anchor Books.

Berk, Marc L. and Claudia L. Schur. 2001. "The Effect of Fear on Access to Care Among Undocumented Latino Immigrants." *Journal of Immigrant Health* 3(3): 151-156.

Bernstein, Nina. 2007. "Immigrant Entrepreneurs Shape New Economy." *New York Times*, February 6. Retrieved April 24, 2011 (http://www.nytimes.com/2007/02/06/nyregion/06entrepreneurs.html?_r=1&oref=slogin#).

Blizzard, Rick. 2005. "Healthcare Panel: How Do People Choose Hospitals?" *Gallup*, October 25. Retrieved May 26, 2011 (http://www.gallup.com/poll/19402/healthcare-panel-how-people-choose-hospitals.aspx).

Blumer, Herbert. 1958. Race Prejudice as a Sense of Group Position. *The Pacific Sociological Review* 1(1): 3-6.

Bonilla-Silva, Eduardo and Tyrone A. Forman 2000. "'I'm Not A Racist But…': Mapping White College Students' Racial Ideology in the USA." *Discourse & Society* 11(1): 50-85.

Bonilla-Silva, Eduardo. 1997. "Rethinking Racism: Toward a Structural Interpretation." *American Sociological Review* 62(3): 465-480.

Bonilla-Silva, Eduardo. 2001. *White Supremacy & Racism in the Post-Civil Rights Era.* Boulder: Lynne Rienner Publishers, Inc.

Bonilla-Silva, Eduardo. 2002. "We are all Americans!: the Latin Americanization of Racial Stratification in the USA." *Race & Society* 5: 3-16.

Bonilla-Silva, Eduardo. 2003. *Racism without Racists*. Boulder: Rowman & Littlefield Publishers, Inc.

Borjas, George J. 1989. "Economic Theory and International Migration." *International Migration Review* 23(3): 457-485.

Boswell, Terry E. 1986. "A Split Labor Market Analysis of Discrimination Against Chinese Immigrants, 1850-1882." *American Sociological Review* 51(3): 352-371.

Brettell, Caroline B. and James F. Hollifield. 2008. *Migration Theory, Talking Across Disciplines.* New York: Routledge.

Bump, Micah N., B. Lindsay Lowell, and Silje Pettersen. 2005. "The Growth and Population Characteristics of Immigrants and Minorities in America's New Settlement States." Pp. 19-53 in *Beyond the Gateway: Immigrants in a Changing America*, edited by E. M. Gozdziak and S. F. Martin. Lanham: Lexington Books.

Capps, Randy, Katrina Fortuny, Wendy Zimmerman, Will Bullock, and Everett Henderson. 2006. "A Profile of the Foreign-Born in the Louisville Metropolitan Area." Washington, DC: The Urban Institute.

Catholic Health Association. 2008. "Catholic Health Care in the United States." Washington, DC: Catholic Health Association of the United States. Retrieved December 1, 2008 (www.chausa.org).

Charmaz, Kathy. 2006. *Constructing Grounded Theory: A Practical Guide through Qualitative Analysis*. London: Sage Publications.

Chavez, Leo R. 2004. "A Glass Half Empty: Latina Reproduction and Public Discourse." *Human Organization* 63(2): 173-188.

Clark, William A.V. and Sarah Blue. 2004. "Race, Class and Segregation Patterns in U.S. Immigration Gateway Cities." *Urban Affairs Review* 39: 667-688.

CNN. 2008. "Campaign Issues". 2008. "Election Center 2008 Primaries and Caucuses." Atlanta: CNN. Retrieved February 3, 2008 (http://www.cnn.com/ELECTION/2008/issues/).

Confessore, Nicholas. 2007. "Clinton Takes Stand on Driver's License Issue (Sort Of)." *New York Times*, October 18. Retrieved April 24, 2011 (http://cityroom.blogs.nytimes.com/2007/10/18/clinton-takes-a-position-on-drivers-licenses-for-illegal-immigrants-sort-of/)

Derose, Kathryn Pitkin. 2000. "Networks of Care: How Latina Immigrants Find Their Way to and through a County Hospital." *Journal of Immigrant Health* 2(2): 79-87.

Devillanova, Carlo. 2008. "Social networks, Information and Health Care Utilization: Evidence from Undocumented Immigrants in Milan." *Journal of Health Economics* 27(2): 265-286.

Documet, Patricia I. and Ravi K. Sharma. 2004. "Latinos' Health Care Access: Financial and Cultural Barriers." *Journal of Immigrant Health* 6(1): 5-13.

Douglass, Frederick. 1955. "The Color Line." Pp. 342-352 in *The Life and Writings of Frederick Douglass*, vol. 4, edited by P. S. Foner. New York: International Publishers.

Douglass, Frederick. 1992. "Parties Were Made for Men, Not Men for Parties: An Address Delivered in Louisville, Kentucky, on 25 September 1883." Pp. 702 in *The Frederick Douglass* Papers, vol. 5: 1881-95, edited by J. W. Blassingame and J. R. McKivigan. New Haven: Yale University Press.

DuBois, W. E. B. 1903. *The Souls of Black Folk*. New York: Bantam Books.

Durand, Jorge and Douglas S. Massey. 2004. *Crossing the Border: Research from the Mexican Migration Project.* New York: Russell Sage Foundation.

Durand, Jorge, Douglas S. Massey, and Fernando Charvet. 2000. "The Changing Geography of Mexican Immigration to the United States: 1910-1996." *Social Science Quarterly* 81(1): 1-15.

Durand, Jorge, Douglas S. Massey, and Rene M. Zenteno. 2001. "Mexican Immigration to the United States: Continuities and Change." *Latin American Research Review* 36(1): 107-121.

Elliott, Jim. 2004. "Leaving Gateway Regions: Migratory Flows and Job Outcomes in 'Secondary' Destinations." Presented at the Annual Meeting of the American Sociological Association, August 14, San Francisco.

Emerson, Robert M., Rachel I. Fretz, and Linda L. Shaw. 1995. *Writing Ethnographic Fieldnotes.* Chicago: University of Chicago Press.

Entman, Robert M. 1992. "Blacks in the news: Television, Modern Racism and Cultural Change." *Journalism Quarterly*. 69(2): 341-361.

Escarce, Jose J. and Kanika Kapur. 2006. "Access to and Quality of Health Care." Pp. 410-446 in *Hispanics and the Future of America*, edited by M. Tienda and F. Mitchell. Washington, DC: National Research Council.

Farley, Tillman, Al Galves, L. Miriam Dickinson, and Maria de Jesus Diaz Perez. 2005. "Stress, Coping, and Health: A Comparison of Mexican Immigrants, Mexican-Americans, and Non-Hispanic Whites." *Journal of Immigrant Health* 7(3): 213-220.

Fischer, Mary J. and Marta Tienda. 2006. "Redrawing Spatial Color Lines: Hispanic Metropolitan Dispersal, Segregation, and Economic Opportunity." Pp. 100 - 137 in *Hispanics and the Future of America*, edited by M. Tienda and F. Mitchell. Washington DC: National Research Council.

Fix, Michael, Wendy Zimermann, and Jeffrey S. Passel. 2001. "The Integration of Immigrant Families in the United States." Washington, DC: The Urban Institute.

Frankenberg, Ruth. 2005. *White Women, Race Matters: The Social Construction of Whiteness*. 8th ed. Minneapolis: University of Minnesota Press.

Foss, Sonja. 2009. *Rhetorical Criticisms, Exploration and Practice.* Long Grove: Waveland Press.

Fronstin, Paul. 2005. "The Impact of Immigration on Health Insurance Coverage in the United States." *Notes*. 26(5): 2-9.

Gladwell, Malcolm. 2002. *The Tipping Point: How Little Things Can Make a Big Difference.* New York: Little, Brown and Company.

Gozdziak, Elzbieta M. and Susan F. Martin. 2005. *Beyond the Gateway: Immigrants in a Changing America.* Lanham: Lexington Books.

Gramsci, Antonio. 1987. *Selections from the Prison Notebooks*. New York: International Publishers.

Granovetter, Mark. 1992. "Economic Institutions as Social Constructions: A Framework for Analysis." *Acta Sociologica* 35(1): 3-11.

Guttermacher Institute. 1986. "Prenatal Care Reduces Rates of Low Birth Weight, Perinatal Mortality Among Babies of Poor Women." *Family Planning Perspectives* 18(1): 38-39.

Hakim, Danny. 2007. "Driver's Licenses? Real ID Is a Fork in the Road." *New York Times*, November 14. Retrieved April 24, 2011 (http://cityroom.blogs.nytimes.com/2007/11/14/drivers-licenses-real-id-is-a-fork-in-the-road/)

Hallett, Tim and Marc J. Ventresca. 2006. "Inhabited institutions: Social interactions and Organizational Forms in Goulner's Patterns of Industrial Bureaucracy." Theoretical Sociology 35(2): 213-236.

Hardwick, Susan W. and James E. Meacham. 2005. "Heterolocalism, Networks of Ethnicity, and Refugee Communities in the Pacific Northwest: The Portland Story." *The Professional Geographer* 57(4): 539-557.

Haywood, Andrew. 2007. *Political Ideologies, An Introduction*. Basingstoke: Palgrave Macmillan

Hirschman, Charles. 1994. "Problems and Prospects of Studying Immigrant Adaptation from the 1990 Population Census: From Generational Comparisons to the Process of 'Becoming American.'" *International Migration Review* 28(4): 690-713.

Hollander, Jocelyn and Hava Gordon. 2006. "The Processes of Social Construction in Talk." *Symbolic Interaction* 29(2): 183-212.

Ignatiev, Noel. 2009. *How the Irish Became White*. New York: Routledge.

Jordan, Joanne, Una Lynch, Marianne Moutray, Marie-Therese O'Hagan, Jean Orr, Sandra Peake, and John Power. 2007. "Using Focus Groups to Research Sensitive Issues: Insights from Group Interviews on Nursing in the Northern Ireland 'Troubles'." *International Journal of Qualitative Methods* 6(4): 1-19.

Kim, M., G. Van Wye, B. Kerker, L. Thorpe, T.R. Frieden. 2006. "The Health of Immigrants in New York City." New York: New York City Department of Health and Mental Hygiene.

Kinder, Donald and Lynn. Sanders. 1996. *Divided by Color*. Chicago: University of Chicago Press.

King, Martin Luther, Jr. and James Melvin Washington. 1991. "I Have a Dream." Pp. 217-220 in *A Testament of Hope: the Essential Writings of Martin Luther King, Jr.* San Francisco: Harper.

Lawrence, Charles R. III. 1995. "The Epidemiology of Color-Blindness: Learning to Think and Talk about Race, Again." *Boston College Third World Law Journal* 15(13): 1-18.

Leduc, Nicole and Michelle Proulx. 2004. "Patterns of Health Services Utilization by Recent Immigrants." *Journal of Immigrant Health* 6(1): 15-27.

Lee, Jennifer and Frank D. Bean. 2007. "Reinventing the Color Line: Immigration and America's New Racial/Ethnic Divide." *Social Forces* 86(2): 561-586.

Leech, Geoffrey. 1981. *Semantics*. 2d ed. Harmondsorth: Penguin Books.

Ley, David and Peter Murphy. 2004. "Immigration in Gateway Cities: Sydney and Vancouver in Comparative Perspective." *Progress in Planning* 55(3): 119-194.

Light, Ivan. 2006. *Deflecting Immigration*. New York: Russell Sage Foundation.

Lin, Jan. 1998. "Globalization and the Revalorizing of Ethnic Places in Immigrant Gateway Cities." *Urban Affairs Review*. 34(2): 313-339.

Lippman, Walter. 1922. *Public Opinion*. New York: Harcourt, Brace and Company.

Lipsitz, George. 2006. *The Possessive Investment in Whiteness*. Philadelphia: Temple University Press.

Mather, Mark, Kerri L. Rivers, and Linda A. Jacobsen. 2005. "What the American Community Survey Tells Us About U.S. Immigration." Washington, DC: Population Reference Bureau.

Mendleberg, Tali and John Oleske. 2000. "Race and Public Deliberation." *Political Communication* 17: 169-191.

Mohanty, Sarita A. 2006. "Unequal Access: Immigrants and U.S. Health Care." New York: Immigration Policy Center. Retrieved April 25, 2011 (http://www.ilw.com/articles/2006,0719-mohanty.shtm)

Mohanty, Sarita A., Steffie Woolhandler, David U. Himmelstein, Susmita Pati, Olveen Carrasquillo, and David H. Bor. 2005. "Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis." *American Journal of Public Health* 95(8): 1431-1438.

Morrison, Sharon D., Lauren Haldeman, S. Sudha, Kenneth J. Gruber, and Raleigh Bailey. 2007. "Cultural Adaptation Resources for Nutrition and Health in New Immigrants in Central North Carolina." *Journal of Immigrant Minority Health* 9(3): 205-212.

Naples, Nancy. 2003. *Feminism and Method: Ethnography, Discourse Analysis, and Activist Research*. New York: Routledge.

Obama, Barack. 2008. *The Audacity of Hope: Thoughts on Reclaiming the American Dream.* New York: Random House.

Omi, Michael and Howard Winant. 1994. *Racial Formation in the United States, From the 1960s to the 1990s*. New York: Routledge.

Ong, Paul, Edna Bonacich, and Lucie Cheng. 1994. "The Political Economy of Capitalist Restructuring and the New Asian Immigration." Pp. 3-38 in *The New Asian Immigration in Los Angeles and Global Restructuring*, edited by Paul Ong, Edna Bonacich, and Lucie Cheng. Philadelphia: Temple University Press.

Park, Robert Ezra. 1967. *The City*. Chicago: The University of Chicago Press.

Passel, Jeffrey S. 2005. "Unauthorized Migrants: Numbers and Characteristics." Washington, DC: Pew Hispanic Center.

Passel, Jeffrey S. 2006. "The Size and Characteristic of Unauthorized Migration Population in the U.S. Estimates Based on the March 2005 Current Population Survey." Washington, DC: Pew Hispanic Center.

Passel, Jeffrey S., Jennifer Van Hook, and Frank D. Bean. 2004. "Estimates of the Legal and Unauthorized Foreign-Born Population for the United States and Selected States, Based on Census 2000." Warminster: Sabre Systems, Inc.

Peak, Christopher and John R. Weeks. 2002. "Does Community Context Influence Reproductive Outcomes of Mexican Origin Women in San Diego, California." *Journal of Immigrant Health* 4(3): 125-136.

Pedraza, Silvia and Ruben G. Rumbaut. 1996. *Origins and Destinations: Immigration, Race, and Ethnicity in America.* Belmont: Wadsworth Publishing Company.

Pew Hispanic Center. 2006a. "No Consensus on Immigration Problem or Proposed Fixes, America's Immigration Quandary." Washington, DC: Pew Hispanic Center.

Pew Hispanic Center. 2006b. "The State of American Public Opinion on Immigration in Spring 2006: A Review of Major Surveys." Washington, DC: Pew Hispanic Center.

Pew Hispanic Center. 2010. "Statistical Profiles of Hispanic and Foreign-Born Populations in the U.S." Washington, DC: Pew Hispanic Center.

Pollock, Mica. 2004. *Colormute*. Princeton: Princeton University Press.

Ponce, Ninez, Robert J. Nordyke, and Sherry Hirota. 2005. "Uninsured Working Immigrants: A View from a California County." *Journal of Immigrant Health* 7(1): 45-53.

Portes, Alejandro and Ruben G. Rumbaut. 1996. *Immigrant America*. Berkeley: University of California Press.

Portes, Alejandro and Min Zhou. 1993. "The New Second Generation: Segmented Assimilation and its Variants." *The Annals of the American Academy of Political and Social Science* 530(1): 74-96.

Price, Marie and Lisa Benton-Short. 2007. "Immigrants and World Cities: From the Hyper-Diverse to the Bypassed." *GeoJournal* 68(2-3): 103-117.

Reardon-Anderson, Jane, Randy Capps, and Michael Fix. 2002. "The Health and Well-Being of Children in Immigrant Families." Washington, DC: The Urban Institute.

Rodgers, Katie. n.d. "Colorblind or Jim Crow? Using Racial Discourse to Frame the Native American Mascot Issue." (unpublished manuscript)

Roediger, David R. 2007. *The Wages of Whiteness*. London: Verso.

Rubin, Herbert J. and Irene S. Rubin. 2005. *Qualitative Interviewing: The Art of Hearing Data*. 2nd Ed. Thousand Oaks: Sage Publications, Inc.

Ryan, Carey S., Jennifer S. Hunt, Joshua A. Weible, Charles R. Peterson, and Juan F. Casas. 2007. "Multicultural and Colorblind Ideology, Stereotypes, and Ethnocentrism among Black and White Americans." *Group Processes & Intergroup Relations* 10(4): 617-637.

Searight, H. Russell. 2003. "Bosnian Immigrants' Perceptions of the United States Health Care System: A Qualitative Interview Study." *Journal of Immigrant Health* 5(2): 87- 93.

Singer, Audrey. 2004. "The Rise of New Immigrant Gateways: Metropolitan Immigration in Context." Washington, DC: The Brookings Institute.

Singh, Susheela, Aida Torres, and Jacqueline Darroh Forrest. 1985. "The Need for Prenatal Care in the United States: Evidence from the 1980 National Natality Survey." *Family Planning Perspectives* 17(3): 118-124.

Skop, Emily and Cecilia Menjivar. 2001. "Phoenix: The Newest Latino Immigrant Gateway?" *Yearbook of the Association of Pacific Coast Geographers* 63: 63-76.

Staiger, Annegret. 2004. "Whiteness as Giftedness: Racial Formation at an Urban High School." *Social Problems* (51)4: 161-181.

Stempsey, William E. 2001. "Institutional Identity and Roman Catholic Hospitals." *Christian Bioethics* 7(1): 3-14.

Stephan, Walter G., Oscar Ybarra, and Guy Bachman. 1999. "Prejudice Toward Immigrants: An Integrated Threat Theory." *Journal of Applied Social Psychology* 29(11): 2221-2237.

Suro, Roberto and Audrey Singer. 2002. "Latino Growth in Metropolitan America: Changing Patterns, New Locations." Washington, DC: The Brookings Institute.

Telles, Edward E. 2010. "Mexican Americans and Immigrant Incorporation." *Contexts*, 9(1): 28-34.

Thomas, Richard K. 2003. *Society and Health, Sociology for Health Professionals*. New York: Kluwer Academic/Plenum Publishers.

Twine, Frances Winddance. 2000. "Racial Ideologies and Racial Methodologies." Pp. 1-34 in *Racing Research, Researching Race*, edited by Frances Winddance Twine and Jonathan W. Warren. New York: New York University Press.

United States Conference of Catholic Bishops. 2001. *Ethical and Religious Directives for Catholic Health Care Services, 4th edition*. Washington, DC: NCCB/USCC, Retrieved May 8, 2011. (http://www.usccb.org/bishops/directives.shtml)

U. S. Department of Health and Human Services. 2009. *Hispanic/Latino Profile*. Washington, DC, Retrieved April 24, 2011 (http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=54)

U.S. Bureau of Labor Statistics. 2008. "Career Guide to Industries." Washington, DC: U.S. Department of Labor. Retrieved December 2, 2008. (http://www.bls.gov/oco/cg/cgs035.htm).

Weber, Max. 1947: The Theory of Social and Economic Organisation. New York: Oxford University Press.

Weiss, Robert S. 1994. *Learning from Strangers: The Art and Method of Qualitative Interview Studies*. New York: The Free Press.

Wetherell, Margaret and Jonathan Potter. 1992. *Mapping the Language of Racism: Discourse and the Legitimation of Exploitation*. New York: Columbia.

White, Kenneth R. 2000. "Hospitals Sponsored by the Roman Catholic Church: Separate, Equal, and Distinct?" *The Milbank Quarterly* 78(1): 213-239.

Wise, Tim. 2010. *Colorblind, The Rise of Post-Racial Politics and The Retreat from Racial Equity*. San Francisco: City Lights Books.

Wright, Richard and Mark Ellis. 2000. "Race, Region, and the Territorial Politics of Immigration in the US." *International Journal of Population Geography* 6(3): 197-211.

Zavella, Patricia. 2000. "Latinos in the USA: changing socio-economic patterns." *Social & Cultural Geography* 1(2): 12.

Zuniga, Victor and Ruben Hernandez-Leon. 2005. *New Destinations: Mexican Immigration in the United States*. New York: Russell Sage Foundation.