

The Undeserving Other:
A Study of Service and Healthcare Providers' Perspectives on "Latino-ness" in Williamsburg

By

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Part One: Background Information and Literature Review

Introduction

“The historic dream of public health...is a dream of social justice” (Gostin and Powers 2006: 1053). The public health perspective centers on a commitment to the idea that all people are entitled to protection against the hazards of this world and to the reduction of death and disability (Levy and Sidel 2006). However, social inequalities complicate this dream and jeopardize community health. As the United States becomes more diverse, health care providers will increasingly see more patients of varying cultural backgrounds with a broad range of perspectives regarding health. Varying social and cultural backgrounds affect communication. Provider-patient communication influences patient satisfaction, their adherence to medical instructions, and thus, health outcomes. Poor health may result if providers do not reconcile the sociocultural differences between patient and provider in the clinical encounter.

Acknowledging public health as an issue of social justice gives rise to public policy goals, such as “improving the public health system, reducing socioeconomic disparities, addressing health determinants, and planning for health emergencies with an eye on the needs of the most vulnerable” (Gostin and Powers 2006: 1054). The increasing gap between the rich and poor leads to an unfair distribution of resources. Discrimination and racism hinder medical access and the quality of care. Additionally, the disenfranchisement of specific groups from the political process silences their troubles and concerns. Social inequalities result in increased rates of disease, injury, disability and premature death.

Multiple social factors affect health, including poverty level, housing, education, and conditions in the home environment, such as family dynamics and safety (Gostin and Powers

2006). Such determinants greatly affect the most vulnerable in a population and create systematic disadvantages regarding health that limit individuals' life chances.

In the United States, the dominant view is that health is a matter of personal responsibility (Gostin and Powers 2006). Additionally, public opinion is skeptical of the government's ability to ameliorate socioeconomic disparities and declares that "the field has strayed beyond its natural boundaries" when public health turns its attention to broader health determinants, such as poverty and racism (Gostin and Powers 2006: 1055).

In order to show respect for all members of society and promote social justice, policy makers and health care providers must consider all factors that determine health, including cultural differences. Failure to do so will perpetuate the current gap in health outcomes.

For immigrant groups issues of legality and documentation complicate access to healthcare. As undocumented immigrants, many will find it difficult to assimilate into their new surroundings and "may find their full incorporation into the new society blocked because of their immigration status and the larger society's view of them as 'outsiders'" (Chavez 1991: 259). Indeed, as scholars have maintained, "the undocumented have been denied fundamental human rights and many rudimentary social entitlements, consigned to an uncertain sociopolitical predicament, often with little or no recourse to any semblance of protection from the law" (De Genova 2002: 439).

In the United States, many believe that undocumented Latino/a immigrants are undeserving of public health initiatives and services. As Chavez (2008) describes, Americans embrace a "foreigners last" perspective regarding public healthcare, while "the term 'American' becomes a synonym for privilege, at least relative to Latinas" (Deeb-Sossa 2007: 763). Latino/a immigrants are the non-American "other," and "their racialization as others, often reflected in

their legal nonexistence as undocumented immigrants” limits their access to healthcare (Deeb-Sossa and Bickham Mendez 2008: 616).

Drawing from interviews with fourteen healthcare and social service providers, as well as participant observations at a local low-income clinic, this study examines professionals’ perceptions concerning the needs of Latino/a immigrants in the community and the barriers that patients face when accessing healthcare. I analyze the ways in which these healthcare workers and service providers define and construct the category of "Latino." The study examines providers’ interpretations and assumptions regarding cultural differences as they affect patient care. I argue that despite these providers' best intentions and commitment to providing healthcare to underserved populations, many of their approaches to and understandings of the category of "Latino" actually contribute to a process of "othering" that defines Latinos/as as outside of the "imagined community" of Williamsburg, and, indeed, the nation (Anderson 1985).

My findings report the language that service and healthcare providers use to describe their impressions and perceptions of the Latino/a and Latino/a immigrant population they serve. I divide the results into seven sections. I first describe the respondents’ justifications for the care they provide for Latino/a patients. Next, I report the providers’ perspectives regarding the cultural differences of the Latino/a population they serve. This section includes subsections pertaining to gender relations, diet, child rearing practices, religion, financial barriers, and “cultural competency.” In the third section, I report specifically on the concept of language as discussed by the providers. Then, I describe how service and healthcare providers discuss issues of equality versus sameness. Next, I report issues of documentation and eligibility Latino/a immigrants encounter, and the fifth section describes how providers perceive and construct the deserving “community” based on these issues of eligibility and documentation. Finally, the

seventh section discusses providers' perceptions of patient compliance, and I examine how the respondents' discourse contributes to the "othering" of Latinos/as.

Healthcare and Racial and Cultural Diversity

Healthcare at a National, State, and Local Level

In 2006, 43.9 million Americans under the age of sixty-five did not have health insurance coverage. The South and the West, areas with large Latino/a populations, had uninsurance rates of 21.1 and 18.8 percent, respectively. However, only 11.2 percent of people living in the Northeast or 13.4 percent of those in the Midwest lacked health insurance coverage (Centers for Disease Control and Prevention 2006). In 2006 in Virginia, fifty-seven percent of Latino immigrants were uninsured. Twenty-seven percent of Latino citizens lacked insurance, and fourteen percent of all Virginians were uninsured (Cai 2008). The Virginia Atlas of Community Health estimates that 17.7 percent of adults in Williamsburg, 11.6 percent in James City County, and 12.4 percent in York County were uninsured in 2004. This equates to an average rate of 12.57 percent uninsured for the Historic Triangle, which is slightly better than the rate in 2001 of 13.1 percent (Williamsburg Community Health Foundation 2006). These figures are lower than 13.6 percent for Virginia and 17 percent for the United States (Centers for Disease Control and Prevention 2006).

Between 2005 and 2006, 5.5 percent of those living in the United States did not receive medical care due to cost and inability to pay, while 3.8 percent of those living in Virginia did not receive care, attributed to this same reason. Within a twelve-month period in 2005 and 2006, 11.7 percent of all children under the age of eighteen living in the United States did not receive

any form of healthcare in an office or clinic. Among white children, 11.3 percent went without any healthcare visits during this time. This statistic increased for Latino/a children, as 17.4 percent did not receive healthcare in an office or clinic within the twelve-month period (Center for Disease Control and Prevention 2006).

Virginia's health insurance program for children, FAMIS (Family Access to Medical Insurance Security) provides health care coverage for children who are not eligible for traditional Medicaid. In 2002, 83 percent of eligible children in James City County, 65 percent in York County, and 40.3 percent in Williamsburg received FAMIS and/or Medicaid benefits. By 2003, James City County had enrolled nearly all eligible children and York County had reached 84 percent. However, Williamsburg had only 38.5 percent enrollment. Statewide 82.9 percent of eligible children were enrolled in 2002 and this number increased to 90 percent in 2003. Though Williamsburg's enrollment rates increased to the mid-80's by 2005, "much of this region lags behind the rest of the state in this indicator" (Williamsburg Community Health Foundation 2006).

The percentage of women obtaining prenatal care serves as an indicator of the community's overall health status. Between 2002 and 2004, 83.8 percent of pregnant American women of all races received prenatal care beginning in her first trimester. In Virginia, this number was slightly higher, with 85.4 percent of women receiving first trimester care. In the United States, 88.9 percent of white women received this care. The number was again higher with 90.5 percent of white Virginians receiving prenatal care starting in the first trimester. However, the numbers are lower for Latina women. In the United States, 77.1 percent of pregnant Latina women begin receiving prenatal care in their first trimester. However, only 71.1

percent of Latinas who were pregnant and living in Virginia receive first trimester prenatal care (Center for Disease Control and Prevention 2006).

In 2006, approximately 85 percent of white pregnant women in Virginia sought prenatal care during their first trimester, 97 percent sought care by their second trimester, and over 99 percent received some form of prenatal care by their third trimester. However, only 70 percent of pregnant Latina women received prenatal care during their first trimester. By their second trimester, 90 percent of pregnant Latina women receive prenatal care, and 97 percent received prenatal care during their third trimester (Virginia Health Equity Report 2008: 25).

Demographics of Williamsburg and the Historic Triangle

According to the 2008 Service Area Needs Assessment, approximately 81 percent of the population in the Historic Triangle is white. In James City County, 2.1 percent of population is Latino/a, while 3.6 percent and 2.8 percent of York County and Williamsburg is Latino/a, respectively (Williamsburg Community Health Foundation 2008). Despite these small percentages, the area's Latino/a population had a significant growth between 1990 and 2000. The Latino/a population increased 70 percent in James City County, 474 percent in Williamsburg and 134 percent in York County during the decade. The Virginia Employment Commission predicts that these three localities will have populations that are 79 percent white and 21 percent non-white by the year 2010 (Williamsburg Community Health Foundation 2006).

Compared to Virginia, James City and York Counties have lower percentages of those living below the poverty line (in 2002, a single, unrelated person with an income of less than \$8,729 or a family of four, earning less than \$17,691). However, approximately twenty percent of Williamsburg's population lives below the poverty line, twice the Virginia average and more

than the United State's average of twelve percent (Williamsburg Community Health Foundation 2008).

Only five percent of those currently living in the Historic Triangle are foreign-born. Approximately seven percent speak a language other than English in their homes. In Williamsburg, forty-five percent of those born outside of the United States arrived in the United States between 1990 and 2000. 30.4 percent of the foreign-born in James City County and 27.6 percent of the foreign-born now living in York County came to the United States between 1990 and 2000 (Williamsburg Community Health Foundation 2006). Sixty percent of Virginian Latinos are United States citizens (Cai 2008).

Between 2000 and 2006, the number of students receiving English as a Second Language (ESL) classes through the Virginia public school system more than doubled, increasing from 36,799 students to 78,216 students (Office of Minority Health 2007). In 2007, 1.7 percent of students in Williamsburg/James City County public schools had limited English proficiency (Williamsburg Community Health Foundation 2008). The rapid increase in ESL students in the Williamsburg/James City County and York County school system accompanies an increase in non-English speaking clients at local social service agencies. For example, between 2003 and 2006, Child Development Resources (CDR) experienced a nine-fold increase in Spanish speaking clients (Williamsburg Community Health Foundation 2006). This growing enrollment in ESL reflects the 110 percent growth rate of Latino/as to the Williamsburg area between 1990 and 2000 (Deeb-Sossa and Bickham Mendez 2008: 621).

Latinos/as in Williamsburg

Latino/a immigration into Williamsburg, Virginia began in the 1990s. The tourist industry draws Latin American immigrants due to abundant opportunities for low-wage jobs,

such as groundskeepers of gated communities and golf courses, kitchen staff in restaurants and hotels, or construction workers on one of many housing development sites. Due to the industries' need for manual workers, "Latina/Latino migrants are welcomed primarily as laborers" (Deeb-Sossa and Bickham Mendez 2008: 621).

However, newly built housing developments displace Latinos/as into segments of low-income housing. Many Latino/a immigrants have difficulties traveling around Williamsburg "due to sporadic public transportation and few pedestrian walkways" (Deeb-Sossa and Bickham Mendez 2008: 621). This housing arrangement and lack of public transportation isolates Latinos/as and "impedes the expansion of migrant networks that could foster migrants' social, economic and physical mobility" (Deeb-Sossa and Bickham Mendez 2008: 622). There are few community spaces, such as migrant-owned businesses or churches, where Latino/a migrants can network or socialize. Networking with other Latino/a migrants is a valuable way Latinos/as relay and share information. However, isolation and a lack of mobility impede assimilation into the larger Williamsburg society. Latina women are most likely to stay within their residences at all times to take care of their children, and "women's restricted physical mobility inhibits Latinas' ability to participate in public life, find better jobs, and access resources in the community that might increase their economic mobility" (Deeb-Sossa and Bickham Mendez 2008: 623).

Both Latina and Latino undocumented migrants fear deportation. Since men spend more time commuting to and from work and in the public sphere, they have a greater risk of being stopped by law enforcement officers, which may result in detainment or deportation. Women fear separation from their children who were born in the United States. If Latina mothers are deported, they may go a long time before they can see their children again. Additionally, a

Latina woman depends heavily on her male partner for economic stability; if he is deported, the Latina migrant may have no other means to provide for her children and herself. Finally, Latina women are less likely to report criminal activity to the police, particularly domestic violence, because they do not want to draw attention to themselves and their families for fear that the law enforcement officers will discover the families' lack of documentation, which will result in deportation (Deeb-Sossa and Bickham Mendez 2008).

Healthcare in Williamsburg and Olde Towne Medical Center

According to the Virginia Economic Development Partnership, over 175 physicians and 50 dentists practice in the area (Williamsburg Community Health Foundation 2006). Additionally, the Sentara Williamsburg Community Hospital offers in-patient medical care. However, "the federal government has determined that the Historic Triangle region has a partially medically underserved population because its low income population may not have enough access to medical care" (Williamsburg Community Health Foundation 2006).

Olde Towne Medical Center (OTMC) is a public-private, non-profit agency providing primary and preventive health care to the population of 135,000 living in the Williamsburg area. The Williamsburg Area Medical Assistance Corporation (WAMAC) operates OTMC. This public-private partnership, established in 1993, addresses "the needs of the region's medically un-served and under-served" (Olde Towne Medical Center 2008a). OTMC operates as a family practice and currently sees an average of nearly 1,200 clients each month for medical and dental services. The OTMC staff is comprised of a Medical Director, paid and volunteer nurse practitioners, physicians, dentists, nurses, the administrative staff and paid and volunteer clerical staff (Olde Towne Medical Center 2008a). The vast majority of OTMC staff members are women. OTMC assesses patient satisfaction using surveys administered on a monthly basis. In

addition to anecdotal feedback from the patient to the provider, a comment box (labeled in both English and Spanish) is located in the clinic's waiting room (field notes).

Only five percent of OTMC patients live outside of the Historic Triangle. The majority, sixty-three percent, lives in James City County, while twenty percent live in the City of Williamsburg, and twelve percent live in York County. Only 29.5 percent of OTMC patients are men, while 70.5 percent are women. Whites make up 42.3 percent of the patients that OTMC serves. Blacks make up 38.2 percent, and 14.7 percent of their patients are Latino/a (Olde Towne Medical Center 2008b). However, a top administrator at OTMC estimates that seventeen percent of their patients are Latino (field notes). Only two percent are Asian, and 2.7 percent identified as "other." The majority of patients, 66.8 percent, are between the ages of nineteen and sixty-four years old. Twelve percent are between the ages of one and eleven years old, while 7.7 percent are between twelve and eighteen. At the margins, 3.7 percent of Olde Towne Medical Center's patients are less than a year old, while 7.8 percent of the patients of over the age of sixty-five (Olde Towne Medical Center 2008b).

Olde Towne Medical Center's Sliding Scale

Olde Towne Medical center charges patients based on a sliding fee scale. OTMC determines a patient's position on the sliding scale based on his or her total household income. The clinic requires proof of income every six months to determine how much the patient must pay. To demonstrate one's proof of income, a patient may submit at least three of his or her most recent pay stubs (including the spouse's pay stubs if the patient is married), a copy of a welfare benefit letter, a copy of a social security check or award level, a verification of child support, a bank account statement that is not more than three months old, or a form of retirement income verification. Additional verification of income may include a letter from the patient's

employer, an unemployment notice for the Virginia Employment Commission, a letter of eligibility for food stamps, AFDC check stubs, TANF, a Medicaid card for the current month, or an Medicaid HMO card.

In order to qualify for the sliding scale at OTMC, patients must provide proof of local residency in James City, Williamsburg, or York County. Documents to prove this residency include Virginia voter registration card, Virginia vehicle registration card or title, an IRS tax reporting W-2 form from within the past eighteen months, an utility bill with the patient's name and address, a residential lease agreement, or a Home Caseworker letter on the organization's letterhead. Patients must present two of these proofs of residency. Additionally, patients must verify their identity by presenting a Virginia driver's license, an United States birth certificate, an United States passport, a valid and current Employment Authorization Card, a health insurance card or policy with the patient's birth date, or an unexpired Permanent Resident card. Without the required documentation of residency, a patient will not qualify for the sliding scale and must pay the full fee at the time of his or her appointment (Olde Towne Medical Center 2008c).

Title VI Obligations

Title VI of the 1964 Civil Rights Act prohibits organizations that "engage in discriminatory practices" to benefit from federal funds (Rosenbaum 2004: 93). Title VI orders "that no person shall 'on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance,'" quoted by Rosenbaum (2004: 93). Compliance with Title VI is not limited to intentional acts of discrimination such as intentional segregation and exclusion of minorities. Title VI compliance also includes *de facto* consequences and "the use of seemingly neutral 'criteria or methods of administration' which 'have the effect of

subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing' accomplishment of the purposed of Title VI" quoted by Rosenbaum (2004: 93). All federally assisted programs must comply with Title VI mandates, and "the term 'federal financial assistance' includes grants, training, equipment, donations of surplus property, and other assistance." (Rosenbaum 2004: 94). Programs that receive funding from Medicaid or State Children's Health Insurance Program (SCHIP) must also comply with Title VI. Olde Towne Medical Center accepts grant money and Medicaid as a form of insurance; therefore, OTMC must comply with Title VI obligations. OTMC must prioritize spending in a context of very scare resources, complicating the ability to balance the clinic's Title VI obligations with cost.

In the 1970's, the *Lau vs. Nichols* United States Supreme Court decision interpreted Title VI to include discrimination on the basis of language. This decision protects the rights of individuals with limited English proficiency (LEP persons), and "LEP persons are defined as persons who 'do not speak English as their primary language and who have a limited ability to read, write, speak or understand English.' These individuals may be eligible to receive 'language assistance' with respect to benefits, services, and health care encounters." (Rosenbaum 2004: 94). "Language assistance" includes the availability of translated materials and interpreters. Title VI language obligations demonstrate the potential for discrimination if language assistance services are not consistently available, and "the LEP guidelines are a testament to the importance of reducing language barriers to federally assisted services" (Rosenbaum 2004: 95).

The following literature review describes the effects of immigration status on availability and quality of healthcare.

Review of Literature

Immigration status is a significant contributing factor affecting racial and ethnic disparities in insurance coverage and access to care. Recent policy changes limit immigrants' access to insurance and healthcare. Immigrants are less likely to have Medicaid or job-based insurance. Latino/as have the highest uninsurance rates among all racial and ethnic groups living in the United States (Ku and Matani 2001). When controlling for health status, income, race and ethnicity, and other factors that affect insurance status and utilization, Latino adults who are not citizens are 2.5 percent less likely to have Medicaid coverage, 8.9 percent less likely to have job-based insurance coverage, and have an 8.5 percent higher probability of being uninsured than all American citizens (Ku and Matani 2001).

Due to cultural and legal obstacles, Latino/a foreign-born children face greater barriers to access to care than their white counterparts. According to the National Health Interview Survey (NHIS), foreign-born children of working poor families are two and a half times more likely to be uninsured than children born in the United States of the same economic status (Guendelman, Schauffer, and Pearl 2001: 261). Therefore, they are less likely to seek care in a doctor's office and the intervals between visits are longer than native-born children. Among insured children, foreign-born were less likely than native-born to have a regular care source or to have visited a physician within the past year. This lack of care could be due to many programs' exclusion of undocumented children. For example, the State Children's Health Insurance Program (SCHIP) does not cover children who do not have proof of legal residency (Guendelman, Schauffer, and Pearl 2001).

There are 11.9 million unauthorized immigrants in the United States (Pew Hispanic Center 2009). Many avoid seeking healthcare except in cases of emergency for fear of detection

and deportation; “under these circumstances, prevention is almost nonexistent because people do not have access to the (formal) system that usually provides it and, thus, they tend to wait until a health problem becomes serious to seek medical care” (Menjivar 2002: 442). Recent legislation created additional barriers to attaining care.

For example, in 2006 President George W. Bush approved the addition of the Medicaid Citizenship Documentation Requirements provision to the Deficit Reduction Act (DRA). Made effective as of July 1, 2006, the provision requires specific documentation, proving identity and United States citizenship, in order to apply for Medicaid. Republican Representatives Charlie Norwood and Nathan Deal of Georgia proposed this additional provision to the DRA in order to “prevent undocumented immigrants from enrolling in Medicaid” (Hitov and Youdelman 2006).

Changes at Olde Towne Medical Center reflect the new federal law, impeding Latino/a patients ability to access care. According to the Olde Towne Medical Center Patient Handbook, patients must present proof of residency and identity and verification of income to qualify for the sliding fee scale.

Effects of Legality

In addition to cultural differences among Latino/a immigrant patients, access to care is often affected by documentation status. Patients’ attainment of the required state-issued identification and proof of legal residency determine their eligibility for social services such as Medicaid or for reduced fees on sliding scales based on income. Without such documentation, the law categorizes the Latino/a immigrants as “illegal” and thus, ineligible and undeserving of social services in the form of medical treatment. Susan Biber Coutin’s research on the production of “illegality” in multiple aspects of everyday life “points out a variety of ways that surveillance in the United States has been increasingly displaced in recent years from

immigration authorities...to private citizens... [including] charitable organizations who scrutinize immigration documents as a condition of their social service provisioning” (De Genova 2002: 426). Social service and healthcare providers triage patients and determine whether a patient is eligible based on the providers’ interpretations of the documentation laws. In doing so, these providers act as the “gatekeepers” to care, and “the institutional positions of gatekeepers in social services and clinics placed these workers, mostly women, in the role of border enforcers. Sociocultural markers such as race and language skills, as well as institutional ones such as social security numbers and state-issued forms of identification, become badges of social inclusion and entitlements to public goods (Deeb-Sossa and Bickham Mendez 2008: 627).

Society ascribes the title of “illegal alien” to undocumented, Latino/a immigrants. This term reinforces that undocumented Latinos/as are outside of the community and “undeserving” of care; thus, they are not legitimate members of the community (Chavez 1991: 262).

Ineligibility due to a lack of state-issued documentation, combined with racial differences, intensifies the perception of the undeserving other. The label of “illegal” distances Latino/a immigrants from the “truly deserving citizens” of the United States, and demonstrates the “critical role that the ‘illegality’ of the undocumented plays for disciplining and othering all noncitizens, and thus for perpetuating monolithic normative notions of national identity for citizens themselves” (De Genova 2002: 425).

Concerns over illegal immigration have plagued American history for multiple generations:

Prevalent in the early twentieth century was the belief that providing immigrants with rights, even the equal protection guaranteed by the Fourteenth Amendment, diminished the value of citizenship. This belief still has currency in contemporary debates over allowing undocumented immigrants access to...medical care. To some, such rights and privileges appear as rewards for illegal entry. Rather than

rewarding “illegals,” public opinion often declares that they should be punished and removed from the country. (Chavez 2008: 25)

Undocumented Latino/a immigrants find it challenging to combat stereotypes. Many Latino/a immigrants do not have the resources to challenge their ineligibility or combat public opinion regarding their legal status, for “‘illegalities’ are constituted and regimented by the law – directly, explicitly, in a manner that presumes to be more or less definitive” (De Genova 2002: 424). Legal classifications prove difficult to overturn when attempting to influence and improve public opinion of Latino/a immigrants. Immigrants “become contextualized not as individuals but as signifiers of alarmist rhetoric of excessive population growth and overuse of....social and medical services” (Chavez 2008: 119).

This “othering” greatly impedes Latinos/as’ inclusion into the community and their access to healthcare. A lack of documentation makes Latino/a immigrants the undeserving other and thus invisible to the society. They have no right to the social benefits and resources of documented citizens and are not a part of the “legitimate” community. Chavez (1991) reports that “most interviewees said that their undocumented immigration status was the reason they did not feel part of the community; they associated not having immigration papers with experiences of injustice and perceptions of exclusion” (Chavez 1991: 272). Thus, through their interpretation and enforcement of documentation requirements, service and healthcare providers label undocumented Latino/a immigrants as ineligible and undeserving of care, thereby perpetuating the “othering” of Latinos/as.

Impact of Poverty and Unemployment on Health

Poverty represents an important component of racial disparities with regard to healthcare and health outcomes. Lower socioeconomic classes have shorter life expectancies and more instances of illness than the wealthy. There exists a social gradient to health and life expectancy.

The health gradient runs from top to bottom, with poorer health at every step down the social hierarchy (Blane 2006). Therefore, health policy has expanded to include the social and economic conditions that contribute to illness and individuals' need for medical attention. The further down the social ladder one falls, the likelihood of disease increases and life expectancy shortens. An individual low on the social ladder has twice the risk of serious injury and premature death than someone at the top. The health gradient reveals how sensitive health is to social and economic factors. Disadvantages such as poor education, insecure employment, hazardous or dead-end jobs, poor housing, and difficult family circumstances with little accumulated wealth are social determinants of poor health. Additionally, physiological strain becomes more severe the longer a person lives in such disadvantaged environments (World Health Organization 2008).

While the lower class continuously experiences discrimination, the upper class receives a disproportionate share of wealth and other resources. For example, the wealthiest twenty percent of the United States population owns eighty-five percent of the wealth. This gap is widening; as the rich are getting richer, the poor are getting poorer (Levy and Sidel 2006). One's low socioeconomic status results in poorer health. Poor health then results in a loss in wealth and income, as individuals must use savings to pay medical bills or lose paychecks due to time off for illness. Thus, the cycle continues and the gap widens. There are damaging effects for the entire society if the gap continues to grow, for "societies that tolerate the injustices of great inequality will almost inescapably suffer their social consequences" (Wilkinson 2005: 36).

Egalitarian societies, with a small gap between the rich and poor, have a stronger quality of social relations. These stronger social relations develop a stronger community life, so violence rates are lower. Additionally, egalitarian societies benefit from people who are more

likely to trust each other. This social cohesion and trust within the community, or “social capital,” does not occur when there is great inequality (Wilkinson 2005). However, the income gap in the United States is the widest of all developed market economies. Additionally, the United States has low rates of trust, the highest homicide rates of the developed world, and a shorter life expectancy compared to other developed countries (Wilkinson 2005).

Social relations are poorer in areas where income level differences are greater. However, a more inclusive society is a healthier society (Wilkinson 2005). Therefore, it is vital to ensure equal health opportunities to all members of a society. This will reduce the negative effects poor health has on the lower classes. A healthier society is a more productive society. As productivity increases, the wealth gap will close, alleviating the many negative effects felt by all members of society due to this gap.

Minorities’ low socioeconomic status contributes to the racial disparities in healthcare. Whether measured by income, education, or occupation, it is evident that racial differences in socioeconomic status contribute to racial differences in health. Socioeconomic status contributes to residential segregation, another factor that influences racial health disparities. The poorer areas in which racial minorities live are less sanitary, involve more people living in a confined space, and are prone to violence (Williams and Jackson 2005). In her study of the South Bronx, Kaplan et al. (2006) identified three categories of issues that she believes contribute to racial and ethnic disparities in morbidity and mortality: 1) stress resulting from low socioeconomic status, racism, poverty, and crime, 2) unhealthy behavior resulting from a lack of information, a lack of available or affordable resources, and competing priorities, 3) an inadequate and unresponsive health care system. Additionally, Kaplan (2006) identified issues stemming from a lack of trust and poor communication between the patient and physician. Racial and ethnic minorities also

reported feeling undervalued and disrespected by the health care system. Many recounted stories of humiliating encounters, which they attributed to racial, economic, or other prejudices or stereotypes.

Cultural Competency

In an attempt to improve quality and eliminate racial and ethnic disparities in health care, public health interests are examining the value of “cultural competence.” Proponents of this model claim that “the goal of cultural competence is to create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture, or language proficiency” (Betancourt et al. 2005: 499). According to proponents of cultural competency, the ways in which healthcare professionals interpret and apply cultural competency to their work greatly determines its effectiveness and ability to help Latino/a patients. Proponents believe in a culturally competent healthcare system that involves several components; cultural competent clinical environments include diversity in health care providers and policy leadership, systematic facilities including multilingual services and literature, and training for all health care staff. Those advocating cultural competency believe ethnically diverse health care providers will allow more patients the opportunity to meet with a provider of the same race or ethnicity with similar cultural experiences and understandings, which will establish greater trust between patients and providers. Additionally, resources such as multilingual services and literature will help patients who are not proficient in English understand physician instructions, and thus patients are more likely to follow them. Finally, academia views “cultural competence as the development of a skill set for more effective provider-patient communication” (Betancourt et al. 2005: 501).

“Cultural competency” emerged as an educational strategy to prepare the healthcare workforce to care for diverse populations. Psychologist Paul Pedersen (1988) first introduced the term “multicultural competence” in a mental health publication. However, it would be several years before the term “cultural competence” became popular within institutional settings, such as the medical field. “Cultural competency” emerged as a public health concept because the United States is becoming more diverse, so health care workers will increasingly see patients with a broad range of perspectives regarding health (Betancourt et al. 2005).

According to proponents of “cultural competency,” one way to improve service provision to Latino patients is to employ Latino/a physicians who share a cultural understanding with their patients, as well as language. Interpreters may find it difficult to understand regional dialects of Spanish or may not understand idiomatic expressions and cultural beliefs regarding different illnesses. They might find it difficult to interpret and translate emotional and physiological responses. Improper translation could result in misunderstandings between patient, translator, and medical staff (Torre and Estrada 2001: 100-101).

According to proponents of “cultural competency,” clinics should provide printed material, such as informative brochures or prescription labels, in Spanish to educate or prevent confusion and prescription misuse. The availability of healthcare information and services in a patient’s native language is an important part of cultural competency. Additionally, the “cultural competency camp” believes linguistic competency must entail health promotional and educational materials that are culturally appropriate and at the patients’ literacy levels in order for patients to be able to read and understand.

While cultural competence cannot address all the multiple factors that create disparities in healthcare, there appears to be a link between cultural competence and improved quality of care

for ethnic and racial minorities in the United States (Betancourt et al. 2005). In an attempt to improve quality and eliminate racial and ethnic disparities in health care, public health interests are examining the value of cultural competency and the potential methods to train and promote the concept among healthcare providers. Supporters of cultural competency maintain that the implementation of cultural competent healthcare systems has the potential to help many Latino/a patients, for “the goal of cultural competence is to create a health care system and workforce that are capable of delivering the highest-quality care to every patient regardless of race, ethnicity, culture, or language proficiency” (Betancourt et al. 2005: 499).

Culture’s Effect on Healthcare

Latino/a populations have culturally specific beliefs regarding the body and health. For example, some people of Mexican descent may develop an understanding of the human body based on Mixteca or Aztec cultures (Torre and Estrada 2001). They believe disease came from supernatural causes relating to religion, magical forces, or the natural and physical world. These beliefs vary among Latino cultures and historical contexts. Additionally, the “contemporary concepts of illness and wellness are closely linked to several aspects of historical beliefs” (Torre and Estrada 2001: 24).

Gutmann (1996, 1997) researched the self-perceptions of men and women regarding masculinity and femininity. He criticizes stereotypes of the “macho” Latin male and believes that the concepts of *machismo* and *marianismo* are recent cultural constructs. However, there exists a dominant ideology that cultural values, such as *machismo* among men and *marianismo* among women, may influence one’s decision to seek medical attention. Supporters of cultural competency believe it is important for healthcare providers to understand that “cultural values, beliefs, and attitudes influence help-seeking behaviors” (Torre and Estrada 2001: 25). Such

cultural values may affect symptom recognition and disease management, as well. Cultural values affect the provider-patient relationship, which helps determine whether a patient follows the physician-prescribed regimen. For many Latino/a patients, their “cultural beliefs regarding health and illness shape how a person communicates individual health problems, perceives and interprets symptoms, chooses when and where to go for care, decides how long to stay in care, and evaluates the care received” (Torre and Estrada 2001: 26).

Cultural stereotypes shape publically held beliefs. Undocumented Latino/a immigrants “are not generally regarded as members of the community; they are society’s ‘Others’...As a consequence, the larger society often endows the identity, character, and behavior of the illegal alien with mythic qualities. And like most mythicization, this helps justify and give meaning to the social and economic order” (Chavez 1991: 262). Thus, the belief in these “mythic qualities” perpetuates Latino/a stereotypes, complicating the concept of “cultural competency” and ways providers consider Latino/a cultural differences when administering care.

According to research on healthcare and the Latino/a population, *marianismo* is the belief that women should place the health care needs of their family members before their own. Some studies indicate that *marianismo* and *machismo* affect the provision of healthcare within the Latino/a population. For example, many women put off their own needs in order to tend to the needs of their family, forgoing regular screenings and check-ups. Some have noted that cultural values exist that condemn the allowance of someone else to view or touch the body. This cultural belief does not support self-touch or familiarity with one’s own body. Therefore, in addition to the cost of the screenings, this reluctance may prevent women from performing breast self-exams, agreeing to clinical breast exams, or scheduling regular mammograms (Torre and Estrada 2001: 28).

In addition to breast cancer, colorectal and prostate cancers are also common among Mexican Americans. While their rates are lower than white Americans, Mexicans' five-year survival rates are lower for all three forms of cancer. Sociocultural factors interfere with the screenings needed for early detection. A general lack of knowledge regarding effective treatments or recognition of symptoms may prevent early detection. Also, a lack of healthcare access or use of preventative health services contributes to lower survival rate. However, one must also consider the attitudes and values regarding the human body, especially considering the sensitive and personal areas these cancers affect (Torre and Estrada 2001: 44).

Some researchers argue that it is essential for physicians to understand sexual cultural sensitivity when discussing reproductive health or sexually transmitted infections. Views on sexuality are additional sociocultural factors that affect Latino/a health because “sexuality is usually not discussed openly within the Hispanic culture, which makes it difficult to implement successful prevention programs” (Torre and Estrada 2001: 42).

Machismo may also contribute to domestic abuse, which stems from men's need for power and control in a culture that accepts rigid gender role expectations (Torre and Estrada 2001: 46; Wilkinson 2005). There is evidence to suggest that men's lack of self-esteem may motivate them to abuse their wives and families. This misplaced aggression is an example of the Bicycling Reaction, which is a “tendency for those who have been humiliated to regain respect or pride by asserting superiority over any weaker or more vulnerable groups” (Wilkinson 2005: 224).

Other scholars have documented that Latino/as may rely on folk medicine in the form of home remedies, for “poor immigrants, like the poor in general, have very limited choices regarding medical care, and when they are undocumented their options dramatically narrow”

(Menjívar 2002: 442). Low-income immigrant families may depend on a family member to treat the children and other members who are sick. Mothers often learn of folklore illnesses and remedies through kinship ties. The *curandera/o*, a folk healer, will often use herbal remedies to treat illness. Though many Latino/a immigrants rely “on informal ties and a network of friends and family to procure necessary medical treatment,” resources are often scarce. Therefore, the network must work as a community, so “people and resources are put together to find a treatment for an ailment” (Menjívar 2002: 448). Medicine procured at a cheaper price in a Latino/a’s home country “is usually shared with others, contingent upon illness, relationship, and trust” (Menjívar 2002: 456).

Low-income and uninsured Latino/as will use alternative treatments to avoid medical bills. When discussing treatment regimens with their patients, proponents of “cultural competency” believe it is critical for physicians to understand their Latino/s patients’ potential use of home remedies, for “cultural competency is a process that requires individuals and systems to develop and expand their ability to know about, be sensitive to, and have respect for cultural diversity” (Torre and Estrada 2001: 103). The “cultural competency camp” promotes healthcare providers who value an openness to learn about general and health related beliefs, practices, and traditions. “Cultural competency” supporters believe this will result in an increased awareness and acceptance of varying cultural practices, and effective communication is an important step towards cultural competency.

Part Two: The Study

This study examines understandings among healthcare workers, providers, and administrators regarding cultural differences and the effects of these differences on the healthcare issues facing Latino/a patients in Williamsburg, Virginia. The study analyzes professionals' perceptions concerning the needs of Latino/a immigrants in the community and the barriers patients may face when accessing healthcare. Furthermore, the study allows service and healthcare providers to use their own words in describing their perspectives regarding the care they provide for their Latino/a patients. Employing semi-structured interviews, I address the following questions:

1. How do healthcare workers, administrators, and social service providers in Williamsburg define the Latino "other?"
2. How do these professionals apply their understanding of "Latino-ness" to their work?
3. What assumptions do the providers make regarding the cultural differences of their Latino/a patients?
4. What assumptions do they make regarding the needs of their Latino/a patients?
5. How do the policies and practices of Olde Towne Medical Center address the healthcare needs of Latino/a patients?
6. How do the daily operations and practices of Olde Towne Medical Center compare to the discourses that healthcare workers, administrators, and social service providers articulate?

Methods

To conduct this study, I gathered information from a sample of professional healthcare workers and service providers from Olde Town Medical Center (OTMC), Child Development Resources (CDR), the Network for Latino People (NFLP), and the Rita Welsh Adult Literacy Program (RWALP). I conducted fourteen semi-structured interviews. I performed ten

interviews with members of OTMC at the clinic, two interviews with professionals from RWALP on William and Mary's campus, and two directors from CDR on site in Norge, Virginia. Of the fourteen, three interviewees were men, while eleven were women. I interviewed one African American and one Latina woman; the other twelve interviewees were white. The interviews lasted an average fifty minutes, with the longest interview lasting two hours and the shortest lasting fifteen minutes. I recorded every interview and transcribed the dialogue in its entirety. Using the transcriptions, I coded the interviews, searching for common themes. In this paper, I use pseudonyms when referring to interviewees.

In consultation with Professor Bickham Mendez, I developed a list of contacts at Olde Towne Medical Clinic and other community organizations that work with Latino immigrants in the area. This list served as my initial sample. I then used a snowball sampling method. Using my initial interviewees and my collaboration with local organizations (Rita Welsh Adult Literacy Program and the Network for Latino People), I identified other potential participants for my study.

I supplemented interview data with fifteen hours of participant observation, which I conducted in collaboration with the RWALP. As a volunteer with RWALP, I administered health literacy screenings, allowing me to observe social interactions in the clinic. My presence in Olde Towne's waiting room permitted me to observe the Latino/a population's interactions with healthcare professionals and provided me with the opportunity to make additional contacts for future interviews.

Justification of Methods

Semi-structured interviews allowed respondents the opportunity to express their perspectives regarding healthcare for Latinos and describe how they regard Latinos' cultural

differences and barriers to care. Open-ended questions gave respondents the opportunity to articulate their experiences leading up to their current work with Latino patients. Providers' language demonstrates the assumptions they hold regarding health care access for Latinos, patient compliance, and issues of inclusion versus alienation. Questions revealed the providers' perspective regarding their approach to administering and ensuring quality healthcare and their approach to patients' cultural differences. This method enabled me to analyze the meanings that respondents ascribe to concepts regarding cultural differences and issues of "the Latino community."

My work as an ethnographer allowed me to enter a new subculture. Networking was critical to this process. Maintaining positive relationships with powerful members of this subculture helped me construct a snowball sample. These key players provided me with the names of valuable contacts to further my research and defended my credibility when top administrators were anxious about my presence in the clinic. Conducting health literacy screenings at OTMC allowed me to familiarize myself with the staff of the clinic. The staff of OTMC began to recognize me, as I was regularly in the waiting room conducting health literacy screenings. The first day I conducted screenings, a nurse stopped to ask me about the project. The next time I was at the clinic, she recognized me from across the room, waved, and asked how I was doing. Additionally, the security guard began to recognize me. On my first visit to OTMC, I had to wait at the door until my contact met me by the security desk. However, over time, the security guard welcomed me and permitted me to set up my table and display without any objections.

My presence in the clinic provided several opportunities to meet staff members and arrange interviews. My reputation preceded me, for I would introduce myself to a provider who

would then respond, “Oh I know about you. I’ve seen you around.” While conducting health literacy screenings in the fall, I had the opportunity to introduce myself to a top administrator of Olde Towne Medical Center. I explained my project and asked if I could set up an interview with him when I returned to Williamsburg for the spring semester. He happily agreed. Later in February, while I was conducting more screenings, I caught him while he was walking through the waiting room. I kept my agenda with me and flipped to the date. Within sixty second, we had arranged an interview for the following week.

Access to Olde Towne Medical Center was valuable, as it allowed me to observe the environment of the clinic. I was witness to interactions between the patients and the receptionists upon the patients’ arrival and with nurses when called back for the appointment. I gained a sense for the demographics of the patients and staff at OTMC. When I was not conducting a health literacy screening, I had the opportunity to examine waiting room literature, including magazines, pamphlets, brochures, signs, and posters. Such literature reflects how OTMC takes into account their non-English speaking patients and/or patients with limited literacy skills when presenting health information.

While conducting health literacy screenings, I had the help of a Spanish-speaking William and Mary student to help translate when needed. As I watched my student-volunteer translator conduct health literacy screenings, I observed his interactions with the Spanish-speaking patients and took note of his reactions to these interactions. On our first day performing the health literacy screenings, the student described his interaction as “depressing” and expressed his desire to go back into the examination room to help a non-English speaking patient. He was truly concerned for the Latina woman and wondered, “How is she going to talk to them back there?” Over the months, I observed the student help the Latino patients as they sat

in the waiting room. Occasionally, he would serve as translator, walking back and forth between Latino patient and receptionist, relaying questions and answers. Once he assisted a Latino couple in filling out paperwork. Though the form was in Spanish, the couple had difficulty reading the questions. Therefore, he sat with the couple for ten minutes to help them complete the paperwork. I observed this interaction, and on our drive back to campus, he drove while I asked him questions, taking notes on his experience with the couple.

My collaboration with the Rita Welsh Adult Literacy Program provided me with this access to the Olde Towne Medical Center waiting room. Working with RWALP gave me the legitimacy necessary to work in this environment. My involvement with RWALP legitimized my presence when questioned by the waiting room receptionist. The first time I sat down with a patient to conduct a health literacy screening, the receptionist left her desk and approached me to ask if I had permission to be in the waiting room. I explained my work with RWALP and our approval by the appropriate authorities. She accepted my answer and welcomed me to continue my work. Through this interaction, I experienced the receptionist fulfilling her “gatekeeper” role.

Access to OTMC allowed me to become a part of the clinic environment. My observations in the waiting room supplemented my interviews. I experienced the daily operations of the clinic, practices that would have been invisible to me without witnessing them first hand. For example, I often overheard the receptionist on the phone with patients, including one occasion when she suggested that the patient visit the Lackey Free Clinic, as opposed to OTMC. This exposure deepened my understanding of the Latino experience at OTMC. I was able to compare what I witnessed to what I heard in my interviews. Spending time at OTMC made me feel more a part of the Williamsburg community. While conducting health literacy

screenings for the Rita Welsh Adult Literacy Program, I sat among patients, played with their babies, and listened to their stories. I suddenly felt a part of the world I was writing about; it was real and right in front of me.

Significance of Study

This study deepens our understanding of the ways in which healthcare workers and providers believe they should address the needs of Latino/a patients. It contributes to the study of Latino/a healthcare and explores the providers' attitudes towards cultural differences and their perspectives regarding the socially constructed concept of "cultural competency." More importantly, this study investigates how professionals understand their responsibilities and obligations for providing the best possible care for their Latino patients. The interviews allowed providers to use their own words to describe their interpretations and impressions of the care they provide, specifically for their Latino patients. This language also reveals their concept of the "community" and the work they do to keep "this community" healthy. Therefore, it is valuable to examine how previously held assumptions affect healthcare providers' interpretations of Latino needs and barriers to care, and how they then apply these assumptions to practices and strategies regarding the care they provide for Latinos. The providers' interpretations become the basis for their practices.

My research investigates the challenges and resources of the Latino/a population. It seeks to increase understandings of how healthcare providers interpret the notion of a "cultural competent" healthcare system and apply the concept to their actions. I analyze healthcare providers' assumptions regarding their roles and responsibilities for developing a healthcare system conducive to the growing cultural diversity in their patient population.

Latino/a immigration is increasing throughout the United States, posing greater challenges on the healthcare system to accommodate this growing diversity. As of 2003, the Latino/a population, with over thirty-seven million people, is the fastest growing minority group in the United States, surpassing black Americans (Clemetson 2003). Williamsburg is reflective of this growth occurring across the country. Between 1990 and 2000, the Latino/a population in this area grew 110 percent (Deeb-Sossa and Bickham Mendez 2008: 621). Reports of drastic increases in social services and healthcare use by Latino/as accompany these steep growth rates.

Therefore, this study examines the underserved and growing population of Latino/as in Williamsburg, Virginia and the surrounding areas. With a focus on the perspectives of healthcare workers, administrators, and social service providers, I uncover what they think, report the words they use, and determine the meanings these providers ascribe to the challenges of their Latino patients. The study reveals the providers' understanding for how they as providers fit into the equation. Their understanding and assumptions then shape their practices and behaviors, and thus the quality of care Latinos receive.

Part Three: Findings

Serving the “Underserved”

Through my research, I do not wish to discount the work of dedicated members of Olde Towne Medical Center and other social service agencies who care deeply for their patients and the underserved in Williamsburg. Throughout the interviews, I found that these providers “have a heart for this population” and achieve great personal satisfaction in their work caring for those who would have great difficulty accessing healthcare without the efforts of these organizations. The interviewees consistently describe their love for the work they do, the population they serve, and the non-profit world as a whole. “I love this community...I enjoy working with the particular population we serve. I feel as though I am making a difference. I feel that what we do is meaningful and it’s very rewarding to me,” said Peter, a top administrator at Olde Towne Medical Center. Many described their satisfaction in witnessing firsthand how their work has directly improved patients’ quality of life. Helen, a member of the secretarial staff at Olde Towne, stated, “So I think, speaking for everybody, we all feel like we are contributing to a need in the community and to helping others. And that satisfaction, that knowing and being able to watch people over a period of time to improve through some of our contribution.” Though their salaries are lower than the average private, for-profit medical center, many acknowledge that their careers are “rich in purpose, though not in salary.”

Many providers distinctly said they had no interest in working for a private clinic. Greg, an Olde Towne doctor stated, “Our salaries don’t necessarily compete with what’s in the private sector, but people that work here enjoy working with the particular patients we do, and we get a lot of gratification out of that.” Providers and public service workers believed they would not attain their sense of contribution to Williamsburg if working in a for-profit business setting.

Carl, a physician's assistant at Olde Towne, recounted his previous experience working in a private medical clinic:

When I was working in Northern Virginia, we didn't see anyone who was uninsured, everyone had insurance, usually through private, people had a lot of money up there. Most of our patients were pretty well off, so there's a lot of entitlement. You know, people didn't appreciate what you did for them as much because they just assumed that you were providing a service that they paid for, so here I think that people seem to be a bit more appreciative most of the time, and that's gratifying, knowing that you're filling a need, meeting a need.

The uninsured population of the Williamsburg area, composed primarily of lower socioeconomic individuals, relies on Medicaid and Olde Towne's sliding scale fees. Providers described treating these patients in a holistic manner, serving as "case workers" who address not only medical ailments but also social problems, such as abuse, a lack of food and clothing, or unemployment. The providers described a sense of accomplishment and satisfaction when the care that they provide results in successful health outcomes, which allow their patients to reenter the workforce and improve their quality of life.

Despite an overwhelming sense of enjoyment and personal fulfillment in their work, the medical and service providers described multiple frustrations. Providers explained other facets of their work that create frustrations, including barriers to care, minimal patient compliance, and the healthcare system as a whole. Kelly, an African American woman and registered nurse, expressed frustration with the language barrier present between Latino/a patients and herself. She stated, "But when you know they're there and they're looking all puzzled and it just kind of frustrates you a little bit, you know." Doctor Greg explained:

...a Latino who does not have documentation that they're here legally might not be eligible for some services that someone who was here legally would have access to, but they're still suffering from the same chronic diseases, and it's tough when you see that there's a barrier for care and you wish you could just take care of them. So that can be frustrating sometimes, but I think we do a good job trying to, despite that barrier, work with the patients the best we can.

Providers consider their patients' limited resources, cultural differences, and legal barriers to care as additional challenges.

Despite these societal constraints and limitations, providers experience some frustration due to their patients' lack of compliance. Beth, a nurse practitioner, finds it frustrating to work with patients who have "limited dedication to their health." Though she went on to explain the social factors that limit the time and energy most Olde Towne patients can afford to devote to their health, many providers complained about the number of patients who fail to show up for their appointments, pick up their prescriptions, follow up with additional care, or stick to their weight loss program. While some providers acknowledged the difficulties that the low socioeconomic population faces when fulfilling their healthcare provider's recommendations, other medical and service providers complained about a lack of patient compliance, attributing poor health outcomes to the patients' lack of commitment.

As opposed to condemning individual patients' lack of initiative, other providers cited the healthcare system in United States as the source of their frustration. "I like the medical field," said Julie, a program director at Olde Towne, "But I do find a lot of our current structures entrenched and very challenging and difficult to work with. The fact that we are such a wealthy country that doesn't have healthcare for everyone that's in this country is difficult for me." Additional frustrations lie with the insurance companies. Beth, the nurse practitioner, stated, "The insurance companies don't look at preventative care as reimbursable, and I think that that is very sad for a lot of our patients." She continues, "I'm finding it increasingly frustrating at this point in time the insurance companies changing their medication, the medications that they'll approve...But that, that's the way it is."

Despite their frustrations with either the system or the patients, providers consistently justified the care they provide to their Latino/a patients and the additional time and resources that may be required to provide quality care to the Latino/a population. Providing care for Latino/a patients often requires additional volunteer time in the form of interpreters, additional spending for the reprinting of translated materials, and additional training to provide linguistic and “cultural competency” classes and workshops in order to meet Title VI obligations. When asked to justify the additional commitment required of their organization to help their Latino population, the service providers believe they have the ethical and moral responsibility to help those in need. Carl, the physician’s assistant, stated, “It just seems like the right thing to do, you know. In the end, I’m just looking at a person who has a health need...If I don’t print everything up in Spanish, I’m not going to be able to really effectively treat that problem that they have or I’m going to create more problems because they’re not going to understand.”

Beth, a nurse practitioner, recognizes the “Golden Rule” and suggested, “If we were in another part of the world and had to receive care, we would want someone to try to understand our needs and try to help us.” Greg, a doctor, explained how the larger society must acknowledge an ethical responsibility to provide quality care to all individuals:

...it’s changing the way our community and our nation looks at providing healthcare and I think this is more of a European model, which is maybe socialist, (laughs) but I think you again have a moral and ethical imperative to provide care for those who live in your community. So yeah if people are breaking the law, the federal government needs to do a better job of policing the border or having immigration policy that makes the most sense, but once in our community, it doesn’t make sense from a moral or ethical imperative...I think we have an ethical imperative to serve those who are living in our community and working in our community.

Many providers recognized the emotional strain they feel when presented with a sick and needy patient. Morally, they feel a medical duty to care for all patients, regardless of their legal

status. Kathy, also a nurse practitioner, described the impulse to help regardless of the patient's ethnic background, ability to pay, or legal status:

And when you get in the room, I know it's different with the business office when it's people looking at the dollars, but when you get in the room with a person that's ill, they're not Latino, they're not Asian, they're not Black, they're not White. It's a person that's ill, or especially a mother with a child. It's just a mother who is really worried because their child is sick, and you, and I think and I can say this for the providers here and for probably most everybody, that is not an issue then, legality versus anything else, it's just getting them [help]; they're a sick person.

Providers often present the issue of treating Latino/a patients from a public health perspective, recognizing the risk ill and untreated individuals present to the community at large. They admit that individuals coming to the United States from Mexico, Central America, and South America may not have received appropriate vaccinations. Additionally, Latino immigrants may have communicable diseases that pose risks to individuals in the community with whom the immigrants come in contact. Doctor Greg explained, "There's public health issues, like if they had STDs and they didn't get treatment because they didn't have access to care, or they had tuberculosis, there's multiple examples from a public health standpoint." He continued, "These people are coming from communities where there's higher level of communicable diseases. An example would be Chagas disease, which is something that we did screening on and found patients who had the disease and if they would have given blood donations, it could have been a public health risk to the community." Tonya, a director of a non-profit service organization, asked, "Do you want your child sitting in a classroom with a child who hasn't had any immunization against measles or any of these horrible diseases?" She then asked, "Do we want untreated folks with tuberculosis running around in the community? I think not."

Finally, the providers claim that if a community lacks consistent healthcare, including preventative measures and routine screenings, individuals of this population are more likely to develop acute health issues and will require care that is more expensive. Therefore, failure to provide consistent care will cost taxpayers more in the end. Kathy, the nurse practitioner, noted, “Whether they’re here legally or illegally, we’re still taking pay-in for their healthcare needs, and we can pay for it here very conservatively or we can pay for it in the emergency rooms in the hospitals that cost an incredible amount.” The medical and social services providers maintained that early intervention and prevention is more cost effective in the end and present a “pay now or pay more later” mentality.

In her interview, Helen, a clinical secretary, discussed the expense of relying on the hospital emergency room:

Helen: Well, if we don’t make some facility available to the people who don’t have medical coverage, they’re going to end up in the hospital emergency room. And if the hospital is federally funded, then they’re going to have to see these people when they come in, whether or not they can afford to pay their bill, so the tax payer is going to end up picking up the bill one way or another, and resources as a clinic that can help monitor chronic disease and keep people out of an acute situation where they end up in the Emergency Room is less costly than the Emergency Room visit that the individual without insurance is not going to be able to pay.

Kim: So it saves money down the line.

Helen: It does. And if you maintain the health of a chronic illness on an on-going basis, you keep it from becoming an acute and more costly visit, and ultimately a lifetime issue...Basically it is a preventative measure. The healthier you teach people to maintain their body, the less problems they’re going to have down the road.

Many providers believed Latino patients are more likely to “inappropriately utilize” the emergency room if they have no source of regular healthcare.

In addition to the added costs of acute care in the emergency room versus preventative and consistent care, providers recognized the blow to work productivity when portions of a

community are ill. Decreased work productivity damages the local economy. Kathy recognized the potential financial setbacks:

Plus these people actually, they work in this community. Regardless of what minority they are, they work in this community and they are offering their service. If they didn't get work here, they wouldn't be here. And so I think you have to look past whether you are going to keep Latinos healthy or this healthy or that, you got to look at keeping your community healthy. Because they go and work with everybody else.

Cultural Differences

Many healthcare and service providers acknowledged the distinct cultural characteristics of the Latinos whom they serve. Fewer acknowledged how such cultural differences may negatively affect their Latino patients. Malia, a Latina woman who immigrated to the United States as an adult and is a current director for a local service organization, expressed concern that local healthcare providers do not adequately address cultural differences. She explained the importance of provider awareness:

There are some physicians or clinics that are not aware about the differences of our culture. And when you say culture, it covers many things. You know, the beliefs and also the behaviors and you know I think that is important for doctors or any healthcare providers because to be knowledgeable about that that can improve the communication between the patient and also the healthcare provider. And what is going to be the result, the patient is going to feel comfortable and follow the recommendations and follow the prescriptions.

Improved communication increases feelings of trust of the patients towards the provider. Trust affects the likelihood that a patient will comply with medical recommendations and feel confident to discuss health issues openly with his or her provider.

I spoke to three medical providers at Olde Towne who expressed being keenly aware of the impact culture can exert on health outcomes. Doctor Greg acknowledged that differences could impair his ability to administer quality medical treatment to his Latino patients. He highlighted the importance of “trying to understand the language and cultural differences that

may interfere with appropriate care and having a plan to deal with that, such as interpreters, some language and cultural training for the staff, and but again, it's imperfect." Although aware of the impact cultural difference may have on his medical performance with patients, Carl, the physician's assistant, reflected on his roles and responsibilities when addressing these differences:

And with any patient, no matter what their cultural background is, what their differences in ethnicity or just their values, you have to understand those things because they do come into play as far as what they think about medicine. So I guess the Latino population has specific challenges and needs, so you have to understand those, but every patient that you come across, you're kind of evaluating what barriers that they're bringing with them, what barriers that they have because of past experiences or values or language differences. It's different but in many ways it's the same with every patient, you know I don't know. So I think being attentive to areas where I may be missing something because of the cultural differences.

Additionally, cultural differences may isolate Latino members of the society. The language barrier and limited job opportunities may prevent the community from integrating Latinos into mainstream society. Also, mothers at home with their children are left alone, often separated from the friends and families they left behind in their home countries. Nurse Practitioner Kathy spoke of Latina women, "They are alienated and get depressed at first because they're so isolated. I see that with all of the immigrants." Studies show that Latina immigrant women in the "Nuevo South" are more prone to geographic isolation in low-income apartments and neighborhoods due to housing trends. Latina immigrant women are isolated within the home while caring for children, or they are isolated at work as live-in housekeepers or hotel maids due to the gender-segmented labor market for service sector jobs (Deeb-Sossa and Bickham Mendez 2008).

Gender Relations

Many providers described gender in the Latino community and its impact on the relationships between women and men. The providers depict an oppressive dynamic that is less egalitarian compared to romantic couples of other ethnicities. The providers often viewed the relationships as dated or “old fashioned.” Doctor Greg stated:

They’re more likely to have a more traditional husband wife relationship, where dad will be working and mom will be home with the kids. Mom is more submissive and subservient than the husband, so something more like you might have seen in American culture fifty to a hundred years ago, where as now a days we have more families that have two working, mom and a dad who work and the kids are in school or in daycare, and I think you see that less when you have both Hispanic parents together.

Beth, the nurse practitioner, believed that Latina women will bring their male spouses or companions to their appointments “more than American or non-Hispanic” women. She recounted instances in which she needed to take extra efforts to position herself during exams in order to protect Latina women’s privacy. Beth said, “I see where probably the deference to the man or the male person in their life is greater maybe than for the American female. You know, they’re more, you know, whatever the man wants that’s what they’re going to do.” Beth also finds herself often communicating more with the men. She explained that the women understand less English, so the husbands often explain procedures or recommendations to their wives. Beth assumed that the husbands acquire more English on the job site, while women do not always have the opportunity to leave the home due to their children. Kathy feels that the older male Latino patients do not take her position as a healthcare provider seriously because she is a woman. Kathy said, “Some of the older Latin males look down on women, I think. Even I can even feel that as a female provider, versus a quote male doctor. I think sometimes we are treated kind of as they treat the women in their household.”

Diet

Providers recognize dietary differences between Latino and non-Latino patients.

Providers also mentioned that the Latino population is more likely to use home remedies to cure medical ailments. The differences may present challenges to providers who know little about food customs and are therefore less equipped to provide health recommendations. Doctor Greg explained:

The foods and diet they may eat might be different than from in America we're accustomed to, so if you're trying to give them instructions on lifestyle change to deal with obesity or diabetes or hypertension, the language barrier and the cultural barrier on not understanding the foods that they may eat on a regular basis can get in the way of providing appropriate teaching and treatment of chronic diseases they may have.

The providers agreed that diet can have a significant impact on one's life, whether a patients is trying to loose weight, lower their cholesterol, or control their blood sugar. Doctor Greg is also concerned with the diets Latino parents provide for their children. Greg believed he sees a disproportionate number of overweight Latino children, and Carl agreed, explaining that Latinos' concept of "an ideal weight for children seems a little bit different" than what healthcare professionals or mainstream America believe. Carl continued, "In that population, if a child seems to be what I would consider overweight based upon the charts, they seem to feel like they still need to be eating more, more, more. And so that's a cultural kind of thing that needs to be addressed." Greg claimed that he has a theory regarding the high percentages of overweight Latino children:

In their home countries, I think they probably have less access to resources and food than they might here, and so if they were, let's say in El Salvador like a lot of our patients are, they probably would primarily breastfeed their infants. Here they do the same. They breastfeed, but a lot of times they'll also give the infants formula at the same times because it's available free through WIC [Women, Infants, and Children]...So you end up seeing these kids who are overfed. They'll give a normal amount of breast milk and the normal amount of formula, and they're kids are getting too many calories and rapidly become overweight...if you're coming

from an environment of need and less resources, I think maybe they're overcompensating and overfeeding their kids, and it causes detrimental problems. If you look at the national statistics, the risk of early diabetes and other problems like that and obesity in the Hispanic population is higher...my theory has always been that it's an overcompensation to coming from an area of need to one of abundance and not regulating that well.

Kathy acknowledged these dietary differences but believes she knows enough about the foods Latinos eat that such differences do not pose any problems when she provides care and advice for her Latino patients. She claimed, "The good thing too really in this country, we know so much about their diet because we eat it a lot, you know. So we're quite familiar with the diet. Kathy continued, "So I'm able to give them some, especially if they're diabetic, I'm familiar enough with what they eat, I can tell them about replacements or different things they can do, or different ways they can try to still stick with a lot of their foods that they eat along with their cultural style of food."

Child Rearing

In conjunction with discussing dietary differences, the providers compared child-rearing practices among their Latino and non-Latino patients. Kathy joked, "they like their babies fat." Many providers mention that Latino mothers breastfeed more than other segments of the population, praising this practice as excellent for the baby. However, providers also note that pregnant Latino women will come in to receive prenatal care further along in their pregnancies compared to non-Latino women. This is partially due to the cost of prenatal care and their exclusion from a position on the sliding fee scale. Doctor Greg explained:

I don't know if it's for cultural or financial reasons, they will present to the clinic late for prenatal care. And that's probably one of the reasons, if you look statewide and nation-wide, that Hispanic, if you look at low birth weight and the premature delivery rate, it's higher for Latinos than it is for Caucasians. And part of that may be lack of access to care and also for some cultural reason, coming late to care. Probably in their home countries, they probably get no prenatal care and probably deliver at home if they live rurally, and so I don't think they look at it as something as important to get in right away and get the treatment, and there's adverse consequences to the infant when that happens.

Carl and Greg both believe Latino mothers are more likely to bring their sick children to the clinic even when the illness is not serious. Greg said, “my impression is they might bring their kids in for illnesses that are more mild that we might not see another low income patient bring their child in for, so I think they tend to utilize healthcare more often than sometimes when it may not be as necessary, both in the clinic and in the emergency rooms.” Carl agreed, “They seem to be more sensitive to the children as far as when they are having a fever, they are a lot quicker, I think, to come in and to take advantage of our services than maybe some of the other population. I think we see them a little bit more often for their kids, for colds and stuff like that.”

Similar to their description of gender relations, healthcare providers describe Latino child rearing practices as outdated. Peter, a top administrator, claimed, “In our OB pre-natal program, we’re finding that Hispanic patients in that program come to us with cultural beliefs about what they should do about birthing a child, and it’s kind of antiquated, and so that’s why we offer patient education to these mothers, to bring them into the twenty-first century.” Peter implied that the clinic must try to change the behaviors of their Latino patients, believing Latino cultural practices are old-fashioned and therefore less safe. While early prenatal care helps in the development of a healthy baby, all women should have the right to contribute to their birth plans without medical staff condemning cultural birthing practices. In a more light-hearted and affectionate tone, Kathy said, “I love it when they come in with their babies. They dress the babies up like our parents used to do us to go to quote, ‘the doctor.’” Again referencing American culture of the 1950’s, Kathy described Latino parents’ efforts to “do the right thing” for their children.

Religion

Healthcare and service providers described the impact religious beliefs may have on their Latino patients' perceptions of seizures and irregular brain activity. Carl mentioned reading about Latino patients who believed that they have a curse called the "Evil Eye." He described the difficulties "when trying to treat the seizures in somebody who thinks, or believes, that the cause is more of a spiritual possession, or something like that versus a brain activity issue, so you try to treat them with a medicine, but they don't really fix it, so they may not take the medicine." Kathy gave a firsthand account of a Latino patient who believes his seizures were the result of a hex placed upon his family. She explained, "He was convinced that a hex had been put on him, because this is obviously a very strong belief where he is from. It had been put on his father and his father had died, and this hex had been put on him. And in reality, what he ended up having was seizures, it was a seizure disorder." She described his resistance to conventional medical treatment. Therefore, she contacted a Latino priest to perform what she described as an exorcism on her patient. She said the priest told her, "In some areas it's so strongly believed that you really, you have to do something for the person to ever get better." Based on this experience, Kathy advised, "I think you just have to be open, have an open mind."

A similar incident occurred at the Rita Welsh Adult Literacy Program office in late March, 2009. Paula, a director at Rita Welsh, told the story of how a Latino man, the same man whom Kathy described, who is a student at Rita Welsh, had a minor seizure while working on his English skills with his tutor, a William and Mary student. Since Paula nor the tutor spoke Spanish, another William and Mary student took on the role of translator. Paula recounted, "And so when Andy's translating now, Andy's got this confused look on his face and the EMTs are going, 'So what's he saying? What's he saying?' And he was like, 'Well, he's saying that it's a

curse. What is happening to him is a curse and that he just needs to go to church. And that he doesn't need to go to the hospital.” In the end, the Latino man did not go to the hospital. The William and Mary student translated the consent release form for the man, which stated that he refused to go with the emergency medical technicians to the hospital. During the incident, Paula learned that the man had a history of minor seizures that occur when he fails to take his medication properly. Paula described her impressions of how mainstream American society would view a Latino man who believes he is suffering from a curse, and stated, “We think that it may have been like somebody who is less intelligent or whatever, because you just make those assumptions on appearance.” She continued to say that she now “realize[s] that perfectly bright people have cultural differences and that’s all you’ve ever been told since you were a little kid, that becomes your norm, so it gave me a greater understanding.” Paula provided some assumptions of her own, saying, “We never did determine what his medications were because he probably doesn’t even know, and he certainly doesn’t know the name of it. And it wouldn’t even matter because he probably thinks it was the curse, anyways. He would not be making the correlation between the medicines.” Since the man attributes his irregular brain activity to the curse, Paula presumed he disregards his prescribed seizure medication, since the Latino man does not believe it to be a medical condition.

Financial Barriers

In addition to the cultural differences that affect the health outcomes of their Latino patients, healthcare providers believe financial barriers may prevent Latinos from accessing care. Providers recognized that individuals of a lower socioeconomic status may have transportation difficulties due to a lack of vehicle or a limited budget for public transportation. Due to financial burdens, nurse practitioner Beth said, “I think we are seeing patients trying to kind of spread out

the length of times between visits because of the co-pays and transportation issues.” Carl said he has to try to use creative ways to acquire medications for his patients, whether he simply prescribes generic forms or distributes free samples to tie patients over until they can afford to refill their prescriptions. He explained the added challenges limited financial resources create for his patients, saying, “You really have to find ways to address those problems because we’re both, myself and the patient, consistently presented with those barriers.” Due to their lower socioeconomic status, Doctor Greg believes his Latino patients will often have no health insurance, which will greatly reduce an individual’s likelihood of receiving consistent medical care:

I think often they’re not going have to have health insurance. If they’re working jobs either in undocumented, under the table or their working part time jobs or jobs with small business, under none of those circumstances are those people going to have typical health coverage. And so they’re going to need our services or services of an organization like ours.

Views on Cultural Competency

While providers are able to reflect on their Latino patients and describe ways in which Latino cultural practices are different from their own, there are great disparities among providers regarding their understanding of the need to address these differences in order to ensure adequate care for all patients regardless of their cultural backgrounds. Malia, the Latina woman who is the director at a local service organization and works with the Network for Latino People, described cultural competency as “the ability to understand and to work with a specific population and to understand the region, the language, the behaviors, the beliefs.” However, when I presented the term to Peter, he said, “I’m not even sure if the Network for Latino People, if I’ve heard that term used, and I go to those meetings. We attend. We’re members of the Network for Latino

People.” While Peter does not use the term, the theory of cultural competency is very important to Malia.

While the term “cultural competency” reflects multiple interpretations, it is critical to the health outcomes of Latino patients that providers are able to acknowledge that these patients require specific considerations. When serving a minority or any patient of a different background from themselves, providers must understand and address their patients’ cultural differences in order to work with the patients effectively.

Carl first mentioned “cultural competency” without any prompt from the interview question. He described how understanding a patient’s culture allows for the development of a relationship and promotes a more effective partnership when addressing health needs. Carl elaborated:

I think part of cultural competency is the ability to understand the person, and I think part of the problem in understanding that person is being able to speak to them, because once you can get a relationship with them, then I think you understand them a little bit more and you understand the culture a little bit more and you’re better able to meet them where they’re at...I know that there are some expectations that they might have for what we are supposed to do, or how we are supposed to treat things, and what manner they might have been used to for having those things treated based upon where they grew up or what their culture says. So that’s tough. Ideally, you can kind of figure out what those expectations are and try to safely work within them.

The Network for Latino People offers training designed to help providers learn ways to become more cognizant of cultural differences and the impact these differences have in their patients’ health outcomes. Malia explained that the Network for Latino People will “provide cultural and linguistic competency through our members of the NFLP in the general community that way representatives of the agency will have the ability to understand and work with the population to know more about their ways and behaviors.”

However, it is difficult to study the “Latino culture” due to such vast differences within this minority group. Cindy, an ESL instruction manager and Rita Welsh program coordinator, acknowledged that it is just as difficult to sum up what it means to be Latino as it would be to sum up what it means to be an American. She said her ESL tutors get “information on the learner’s country, which is a great place to start, but it’s very general information. Think about someone trying to generalize American culture.” Cindy hoped her ESL tutors can release their previous assumptions and learn to look at cultural beliefs and behaviors from someone else’s perspective. She said, “I think a lot of it is just awareness, so that when a situation arises you can think outside.”

Tonya, a deputy director of a local service organization, said that her organization does “invest some time and energy in training our staff in cultural competency, so trying to help people expand their repertoire of knowledge about different cultures, and then also kind of reexamining their own personal biases or belief systems.” Tonya applied an interpretation of “cultural competency” to the information she presents in workshops and training sessions. She believed that such efforts to acknowledge cultural differences and adjust beliefs and behaviors based on these differences could theoretically benefit the Latino population.

However, not all service providers walk away from “cultural competency training” with a refreshed sense of responsibility to embrace cultural differences or a motivation to exert extra energies to compensate for cultural differences, which may create additional challenges when serving that population. In September of 2008, I attended a workshop for Child Development Resources staff members entitled “Cultural Competent Professionals.” Held at the James City County Community Center, Tonya facilitated the presentation in a conference room with around sixty-five CDR staff members. We worked in small groups to guess the meaning of a foreign

word assigned to our table. There was a very light-hearted and humorous atmosphere. Everyone was making jokes and laughing as they went around a guessed their word's meaning. At times, the whole room would break into loud laughter. After this exercise, Tonya began to facilitate the presentation. She said that they are "all doing good work working with families from different countries." She told the room that the workshop would include a self-assessment. Tonya said some of the goals for the day's workshop included "heightening awareness of responsibilities, learning fundamentals of cultural competency, examining practices, and indentifying strategies." She acknowledged that this information is "not new, but a reminder."

Despite the feel-good atmosphere, the middle-aged white woman sitting across from me rolled her eyes and sighed heavily. She cracked a joke to the table and in sarcastic tone told me that they have heard all this "a million times." While Tonya valued a specific definition of the term, "cultural competency" evoked different feelings and attitudes from different service and healthcare providers. Despite Tonya's efforts to promote specific values and understandings among service providers that, according to the "cultural competency camp," could in turn benefit Latinos, not all providers ascribe the same meanings and values to the theory.

Language

When questioned about cultural barriers, every respondent discussed communication issues due to Spanish-speakers' lack of the English language. Providers consistently mentioned interpreters in conjunction with the language barrier. For most, language was the first barrier mentioned when asked. For some, it was the only barrier recognized. When first questioned about cultural barriers, Peter responded, "Of course language is a challenge, and as a result of that, we have volunteer interpreters that work here...so language can be a barrier, but we are

trying to meet that through the utilization of these volunteer interpreters. (pause) A lot of our handouts, printed materials, we've had to do in Spanish.” Natalie, a service coordinator, agreed and when asked about volunteer services directed towards Latino patients she responded, “The biggest one of course is translation. We provide translating services for them.” Kelly, the registered nurse, elaborated on the language barrier and the value interpreters have by reducing communication issues:

The communication. The communication is the biggest thing because you think they know and the way their body language, the way they express themselves, but they really don't, and it's very difficult, and trying to provide services for them, and you really want to help them, you know, and it's kind of sad. Because like for the language barrier, it's a big thing. Big problem here. So having the interpreters here is very good and it's very helpful. Because you want to make sure you're saying the right thing, they're understanding and comprehending, so you can provide the best care for them... But yeah communication, the language barrier I think is the biggest problem. Well, I know it's a problem.

Carl described the frustration and concern he feels after providing care for a Latino patient who has limited English. He said, “But there's always the feeling, for me at least, that maybe there were other things that they would have been able to communicate better if we had the same language.” Though Carl is proficient in Spanish and has the most advanced Spanish skills of all health providers at Olde Towne, he admitted that “there have been times where I would not have known exactly what it is that they were wanting, my Spanish was just too limited...There have been times when I have asked people to come back and bring a family member who can speak English or an interpreter for their next visit.” He admitted that he is not always able to describe, in Spanish, the financial system of the clinic or the steps his Latino patients must take when applying for reduced fees. Despite his proficiency, when leaving exams with Spanish-speaking patients, Carl has experienced feelings of dissatisfaction and concern that he was not adequately able to convey important medical information to those patients:

Carl: ...I mean I've often times even called the interpreter and have them call the patient to clarify something for me, to make sure that they understood what my instructions were.

Kim: This is after the fact?

Carl: After the fact, yeah, you know if I don't feel comfortable with it, then I'm going to have them come back or I'm going to have someone else call them.

Recounting her experience as a recent Latina immigrant with very limited to no English, Malia explained that she was three months pregnant when she moved to the United States. She was unable to communicate with her obstetrician when visiting medical clinics for her prenatal care. Malia described the difficulty non-English speakers have when questioned about family and personal medical history and the potential confusion when the provider uses medical jargon. She explained the dangers of miscommunication:

[It is difficult for someone with] limited English to explain all the health issues to a doctor, and also the doctor I think he's at risk to misunderstand what the person is saying because how that doctor going to prescribe medication or how he's going to determine what's going on with that patient if they couldn't communicate. So it's a big risk for the doctor and also for the patient, and I think more for the patient because the life can be in danger.

Miscommunication between doctor and patient can create multiple health issues for the Latino patient. The language barrier is a constant concern for non-English speaking Latinos. Kathy described one of her "biggest" concerns as a nurse practitioner working with Latino patients, saying, "I want to make sure they are understanding what the treatment plan is before they leave. I want to make sure they understand my directions for the medicine or whatever." Beth mentioned her own concerns, saying, "I don't know what they're always saying, and like anything, people's viewpoints can be interjected, and you wouldn't know." Carl described the relief his patients experience when they first realize he is extremely proficient in Spanish. He said, "It's funny to see the look when they don't know and then I walk in and I'm able to speak some Spanish, you can just see they're so relieved sometimes. And that is gratifying as well." Since the other providers know that Carl is proficient, they will call him from his office or

another exam room to come translate for a Spanish-speaking patient who the other medical provider is currently examining.

This need to use Carl, a physician's assistant who is not a trained interpreter, demonstrates a lack of qualified interpreters at Olde Towne. Though some providers are proud to claim that there is "always someone around to interpret," others acknowledged a lack of availability. Julie, the program director, acknowledged "that you need to know if someone doesn't have the facility with the language, so a translator is ready and provided for, and I have seen instances where those two things aren't together at the same time. That's a barrier to care." The community van that travels as a mobile clinic to different sites around Williamsburg does not have an interpreter who accompanies the nurse and nurse practitioner. Beth said that the staff on the van will call an interpreter on the phone, point to words in an English-Spanish medical book, or use "Spanglish" if they "get stuck" when serving a Latino patient who does not speak English. Carl described difficulties Spanish-speaking patients have when "trying to schedule their appointment around when an interpreter is going to be here. They may not always know when that is." While working at the receptionist desk, Megan recalled, "Sometimes they will leave. I don't know if they just get frustrated or because they really just don't understand what's going, then they might leave" due to their inability to communicate or understand the financial system and requirements of the clinic. She said that there are not always interpreters available, especially during the later hours. She referenced a list of interpreters' phone numbers, explaining that they will call them over the phone to interpret if necessary. Megan explained that in some cases, interpreters will come in to the clinic if they live close by and are willing to come to the clinic. Malia believed Spanish-speaking patients do not always have access to interpreters when seeking medical care. She said, "I have received a lot of calls from the Latino community

asking me if we can send an interpreter because they have been asked to bring their own interpreter.”

While the ability to speak Spanish is helpful to their Latino patients, providers should not rely on their own modest Spanish skills or on untrained, though fluent, interpreters to translate for their Spanish-speaking patients. As Cindy pointed out, “There’s a lot of people out there that are volunteers that are good-hearted people but without training I sometimes wonder if they are doing more harm than good.” While Olde Towne prides itself on its volunteer interpreters, other respondents mentioned that acting as an interpreter requires more than simply speaking Spanish. Malia noted, “I think that the kind of job that a lot of volunteers are doing is helpful, but it’s a big risk because no one has been testing their language fluency.” In addition to insuring fluency, interpreter training teaches how bilingual individuals should behave while interpreting in a medical setting. This includes specific techniques regarding where to stand and where to look. Additionally, interpreters in training will learn how to handle issues of confidentiality and impartiality. Natalie admitted that Olde Towne does not require their interpreters to undergo training. However, she believed that their Spanish skills are strong enough, so there is no need for additional training. Kathy said, “We’re pretty good about having interpreters here, or we’ll tell them that they have to bring someone...And I try to make sure they understand, we get on the cell phone while they’re here, if they have a friend or a family member or an interpreter that can understand more English.” A family member, especially a child, is less likely to understand the appropriate interpreting techniques that provide the best health outcomes.

When asked if there are any local resources for Olde Towne interpreters to learn or improve their interpreting skills, Natalie said, “Well, we don’t offer any, as far as that goes, but

they do that themselves in the community,” describing Spanish-speaking community groups that interpreters participate in to keep up their language skills. Though this involvement with the Latino community is commendable, again simply speaking the language does not always qualify one to serve safely and effectively as a medical translator.

Furthermore, there are local organizations that will train bilingual individuals to become quality medical interpreters. The Network for Latino people developed a service called the Community and Medical Interpreters Service (CMIS). CMIS trains individuals in order to promote effective and accurate communication between service providers and Latinos with limited English. CMIS offers its services to all agencies, organizations, community groups, and individuals. The program provides interpreting and translating services in both Spanish and English. Malia said, “The NFLP created CMIS where we train people and they learn about the modes and techniques the interpreters’ code of ethics. And I think one of the important things is the confidentiality.” Malia said that interpreters in training “also learn about Title VI, that is very important so they can help the CMIS ask a program to encourage agencies to use trained interpreters and also because any agency receiving federal funds are obligated under law to provide an interpreter for those people seeking the services with limited English skills.” Tonya agreed, stating:

I would like to see more organizations taking advantages of the services that CMIS has to offer because I think it’s a great service. And if they are using volunteers, I would like for them to use trained interpreters and relying less heavily on family members and children. There are still some folks out there that are relying on the kids to come and interpret for the parents.

Doctor Greg described using the interpreters as “sort of like playing the telephone game.” He admitted, “Anytime you’re not speaking someone’s language and you’re not from their culture, the meaning they’re trying to get across to you may not always come across accurately.”

Kathy acknowledged that though Olde Towne uses interpreters, at times “the interpreter even has problems. I don’t know if it’s a different dialect, or what it is.” Olde Towne may clump different dialects, or completely separate languages of their Latino patients, under the umbrella of “Spanish” when assigning a volunteer interpreter to a case. Untrained interpreters may be unaware of the differences in these languages or dialects. Beth described differences in techniques among the interpreters she works with while serving patients with limited English. She explained her perception on the different methods she has encountered:

Beth: ...There are different ways people do interpreting. I believe the ones who’ve been formally trained try to not establish a relationship with the provider but want you to talk to the patient and they just act as a mouthpiece kind of person. There have been other interpreters who you basically talk to the interpreter and the interpreter turns around and talks to the patient. So I think it depends upon their training as an interpreter.

Kim: Is there a method you find most effective?

Beth: I think I actually find talking to the interpreter and then interpreter talking to the patient, simply because I’m still establishing eye contact with the patient while the interpreter is still there but when you just kind of ignore this person (laughs) on the side, it’s just kind of hard to do with the patient still looking, kind of like, who do they direct their attention to, when you’re talking and then all of the sudden the other person starts talking. But you know, it’s just, I understand why they’re doing that if they want you to establish the eye contact with the patient.

In order for service organizations like Olde Towne to provide effective and fair treatment for their Spanish-speaking patients, the healthcare and service providers need to constantly reexamine and reevaluate the services they offer in order to ensure that these services – the interpreters – are most effective in improving and promoting Latino health. As Paula put it, the interpreter is “the face between the patient and the medical help.” Therefore, this is a critical role in the healthcare setting. Relying on volunteer interpreters and not utilizing local programs that can appropriately train interpreters poses a threat to patients with limited English skills.

Unassimilated Latinos

A reoccurring belief exists among healthcare and service providers that Latinos who have limited English skills lack motivation to learn the English language. Furthermore, some

providers believe that they are “enablers,” claiming that the availability of interpreters and translated materials prevent Spanish-speaking individuals from needing to know the English language. Thus, the providers assume, the Spanish-speaking individuals will feel no need to learn English.

Though some providers believe that Latinos with limited English have little desire to learn, the accounts of different providers prove otherwise. Malia described her desire to search for a job that would challenge her English skills and force her to use less Spanish and more English. She felt a “personal motivation that I need to find any other kind of job that I can improve my English.” Malia said, “We were asking if there was like a school or any program that we could attend to, you know, learn the language so my husband and I enrolled in the adult learning center in Virginia Beach and we were trying to learn English but you know it takes time.” Malia recognized that English is difficult to learn. She explained that it takes years of practice, not something one can pick up in a short time. “It’s just like when people want to learn Spanish.” Malia said, “It’s very good that some agencies here in our community try to train their staff to learn Spanish but that’s not easy. You know in one week, two weeks, one month, you’re not going to learn a new language.” Cindy acknowledged that her Spanish-speaking ESL learners recognize the value of learning English. Cindy said, “Teaching adults is great, especially ESL adults, because it’s so relevant to their lives because they know that if they learn English they’ll get a better job, their children will have a better future.”

Local service agencies are discovering that they need to encourage opportunities for Latinos to learn and practice English. Tonya said that the Latino families she works with want to work with English-speaking families in order to gain more exposure to English. Tonya said, “We’ve encouraged those families to integrate into the other groups, and so now the parent

groups that we have five days a week have a combination of English speakers and Spanish speakers...And one of the things that we hear loud and clear from the families is that they want their children exposed to opportunities to learn English.” Cindy described how she combines her parent support group meetings with English instructions. She used dental health as an example topic, explaining that while learning about the importance of dental hygiene, those attending the class will also learn basic dental vocabulary in English. Tonya described her partnership “with Rita Welsh Adult Literacy program to offer ESL classes on site here, so that the families can improve their English.” She said that she is “going at it from both sides,” by providing ESL classes for Latino and by offering Spanish classes for her own English-speaking staff members. Tonya described her efforts to integrate the Latino population into the “life of the community.” She said, “The purpose behind the Latino Network was really to help these families successfully integrate into the community, to look at how we can address some of the barriers of language, communication, housing, helping them understand what programs they were and were not eligible for, but then also supporting the Latino community into becoming good citizens.” English instruction is a major component of the assimilation plans these organizations support and fund.

Some providers described an environment that makes it extremely difficult for Latinos to learn English. Kathy compared the Williamsburg community Latinos reside in to American military bases overseas:

We have Hispanics that have been here for twenty years that can’t speak English, and they really live in what we tend to do when we go to Europe. Military people, I was over there when my husband was in the military and you live on those bases and you go to your American schools and you never get out and live in that culture, and these people do the same thing. You know, you seek out people that are like yourself.

Cindy agreed that Spanish-speaking individuals have a difficult time practicing their English skills in Williamsburg. She recognized that many Latinos work together in blue-collar jobs in kitchens or on construction sites. They speak Spanish amongst themselves. Cindy believed, “It’s almost become too easy to speak Spanish in the United States, even here is Williamsburg.” She continued, “They are surrounded by Spanish all day long, and they can get Spanish television and Spanish radio stations. They shop at Spanish stores. If they go to Olde Towne Medical Center they can get a Spanish interpreter, so I think that’s one of the biggest hurdles Latinos have is that they really have to force themselves to use English and they may not have the opportunity to be around that many native English speakers.”

Few providers view interpreter services and Spanish classes for English-speaking providers as detrimental to Latinos. However, both Kathy, a nurse practitioner, and Natalie, a service coordinator, believed such resources hinder their Latino patients’ ability to integrate into the larger community. Kathy described Spanish classes she and the other health providers took “because we were seeing so many Latino patients.” She said, “I got where I wasn’t half bad at medical Spanish and then all of the sudden we quit doing it but it was because of the change.” The change Kathy referenced is a change in documentation requirements that determine eligibility for the sliding scale. Kathy believed that through these Spanish classes, and their cancellation, “we have prevented or we have caused or created a barrier.” Maintaining that fault comes from “both sides,” Natalie strongly believed this problem is the result of the non-Latino population who allow Spanish-speakers to avoid the need for English, as well as the Latino population who fail to encourage other Latinos to learn English. Natalie said:

I think their own community does not promote that for them. I mean, the sooner they learn the language, the better it is for them...And I think even we don’t, we become enablers to them. For example, I provide translators. When in the beginning that’s fine, but I like to encourage them to go on and learn the language. The sooner they learn it, the better they will be...in the

community, the more they can do for themselves, the better they will feel about themselves. It's terrible to have to be dependent on somebody, for anything you want, simply because you can't communicate it. And I don't think there's a real push out there to help them do this. I don't think, you know, it's not impressed upon them the importance of this. Every place they go we translate for them, and it just perpetuates the problem

Natalie maintains that there is no push from "both the Hispanic and our population" for Latinos to learn English "because there's always someone there to do it for them." She recognized that that they are busy and believes that Latinos are "not going to do it if there's always someone provided" to translate for them. Natalie believes, "in the long run, that holds them back." She strongly feels that interpreters deter Latinos from learning English. Additionally, Natalie does not believe that the "Latino community" encourages Latinos to learn English. She explained her frustration:

Kim: So is that what you mean by "the community doesn't promote it?"

Natalie: Their community does not. Like Nilf [NFLP, Network for Latino People], are you familiar with that?

Kim: Oh yes.

Natalie: I don't think they promote it. They don't even have English as a Second Language classes.

Kim: This is Network for Latino People?

Natalie: Yeah. I set up some last fall for them, but they cancelled them. They do everything else for them, but do not provide, you know, helping them to overcome the language barrier. You know, that's just the way I see it.

Based on interviews with Cindy, Tonya, and Malia, the Network for Latino People, Rita Welsh Adult Literacy Program, and other local organizations provide ESL classes that allow Latinos the opportunity to improve their English skills.

Natalie does struggle with her concerns that Latinos will not learn the language and assimilate while simultaneously acknowledging interpreters are a necessary evil. She said, "I feel like sometimes we enable them by doing all this, but on the same token, I have to do it for them." She described her personal dilemma in trying to provide interpreter services while

motivating Latinos to learn English. She continued, “I’m encouraging them, but at the same time by providing everything in Spanish, and doing all this, I’m enabling them not to learn, but at the same token, I cannot not do it. Do you see what I’m saying?” Natalie fervently maintained, “I think they’ll be so much happier, so much more secure, be so much more able to do for themselves. (Pause) But we recently had a lady who’s been here twenty years and still couldn’t speak a word of English. I mean that’s not good.”

Equality and Sameness

Providers reinforce the importance of treating everyone the same. They believe all patients must receive the same care and that no provider should treat anyone differently based on a patient’s ethnicity or nationality. Despite their understanding of the multiple cultural differences between their Latino patients and non-Latino patients, providers still maintain that patients must all “be treated the same.” Despite acknowledging a need for interpreters for their Latino patients with limited English skills, providers continue to say that no group should receive special care or additional services compared to another group. This discourse contradicts the service the volunteer interpreters perform for patients with limited English. Regardless of these differences and the fact that Olde Town does in fact provide an additional service for Latinos in the form of interpreters, most providers have the mentality that no segment of their patient population should receive specialized services or attention. However, certain populations in a community are clearly different and, therefore, require different services in efforts to provide equal quality of care. Equality does not mean sameness.

When asked what services Olde Towne provides specifically for their Latino patients, Peter responded, “We provide all of our services to anyone, regardless of their origin.” Julie

answered, “None, I don’t think we provide any specific services for any specific group.”

However, the fact that Olde Towne does provide interpreters demonstrates how their mentality strongly evolves around a concept of sameness, when in reality, non-English speakers receive an additional resource in the form of free interpreters. When asked how Olde Towne manages cultural diversity to ensure adequate care for all patients regardless of their cultural differences, Peter responded, “We don’t segment our services to any particular population. We serve anyone and everyone that is seeking medical and dental services here.” I was not satisfied with this answer and continued to press, to which Peter said, “You’ve got to understand. If I as manager begin to look at population, if I begin to look at minority segments, that’s going to confuse me. We provide services to everyone regardless of their ethnic background or their origin.”

Some would argue that Title VI requires Peter to provide different treatment for his patients with limited English skills. To ease the tension I mentioned Olde Towne’s use of interpreters for Spanish-speaking patients. Peter said, “Oh yeah, we do all of that. Plus our materials, the patient information materials, all that we give out that have pictures or are in Spanish and all. Yeah, we do whatever we can with that particular population, but we do that for everyone.” However, discrimination involves treating different people as if they were the same, as well as treating similar people differently. While all patients may receive health information materials, not all patients need the materials in Spanish. Therefore, Olde Towne must spend the reprinting costs to provide translated literature. This is an example of a specific resource geared for a specific population. Olde Towne does not “do that for everyone” because everyone does not need it. Providers create a barrier to care when they do not acknowledge that different people require different services. As a minority with specific challenges, Latino patients will

need specific resources and services in order to reduce the barriers and eliminate the potential for creating new challenges when accessing healthcare.

Some providers simply list the services Olde Towne offers its general patient population when asked about specific services for Latino patients. I asked, “Specifically, what services does Olde Towne provide for Latino patients?” Helen replied, “Well, we provide full medical care” and then goes on to name the medical services that Olde Towne offers all eligible patients. I asked Peter if he would change anything about the services Olde Towne offers, specifically “the services that are offered to help the Latino patients who might have cultural differences.” Peter replied, “No, no there’s no need to change the primary medical and dental and healthcare services for any particular segment of the population because that’s not the way we do business. We provide primary medical, dental, healthcare services to anyone regardless of their community or origin. We do though, need to provide interpretation services for individuals that do not speak English.” Providers maintain that all patients receive all the same services. Listing all services that the clinic provides for all patients does not demonstrate how Olde Towne addresses cultural differences among patients. Peter contradicts this “sameness” ideology by mentioning Olde Towne’s use of interpreters – a specific service for a specific population.

Some providers understand the need to treat patient populations differently if their specific differences require specific resources, while other providers are still coming to terms with such a concept. Cindy provided an example of different resources that fairly address different groups’ different needs:

There’s a company that we’re doing classes for, for the ESL learners there, and I have wondered how their native English speakers feel since this company is paying for these classes, “what about me?” But the company eventually wants to offer GED classes. So while 70% is ESL, we also do writing, reading, math, and GED preparation. So we do have services for native-English speakers.

However, Carl was torn over the issue of equality versus sameness. Though he acknowledged Latino patients' cultural differences, he felt a need to treat all patients the same. Carl said, "I really try not to think of them in a way as different even though at the same time, understanding their cultural differences you kind of do have to be aware of their differences." He continued, "But each person is deserving of exactly the same measure of care, the same quality of care regardless of their backgrounds." When it comes to cultural differences, in order to produce the same quality care, providers must consider the different resources or services that are necessary.

Natalie feels sameness is appropriate because she believes that Olde Towne has assimilated the Latino population into the community of the clinic; sameness is appropriate because they are now all the same. Natalie said, "We've so assimilated them into our clinic, that they don't have any more real needs than the rest of the people, other than translation and we've done that." Again, a provider recalls interpreters as the only break in sameness. Natalie described the Latino patients at Olde Towne:

They have the same needs as we have, and we try to meet everybody's needs. And they had an extra special need, which was the translation, so we provided that. So we treat all the patients the same. It doesn't matter whether they're Hispanic or they have blue polka dots or what, they're all the same to us and they all get the same service, the same, as much as we can provide, that they need. So we don't really think about them as being Hispanic or you know, another level of patient here. They're just all Olde Towne patients.

Eligibility and Documentation

Providers and patients feel the effects of the Medicaid Citizenship Documentation Requirements provision, which requires specific documentation, proving identity and United States citizenship, in order to apply for Medicaid. Fewer patients qualify for reduced fees according to Olde Towne's sliding scale. Providers report seeing fewer Latino patients after the provision took effect in July, 2006. Many of these Latino patients could not produce the proper

documents in order to qualify for affordable care. Some providers express frustration that they are not legally permitted to serve certain patients or provide discounted fees that allow patients to afford treatment.

Providers described a change in the required documents that their patients must present. The presentation of required documentation determines eligibility for Olde Towne services and a patient's position on the sliding scale, which corresponds to the fee required for the visit, based on patient income. Providers acknowledged that the current documentation requirements often present challenges for Latino patients. Doctor Greg explained, "If they're here legally then those patients under state law can qualify for discounted care, but if they don't have proper documentation, then by some of the state laws can be limiting and so they don't necessarily qualify for the same discounts." When working the reception desk, Megan described the process a new patient must go through in order to make a first appointment. She explained that they must "present a photo I.D....and live in James City, York County, or the City of Williamsburg to receive our sliding scale discount." Megan acknowledged, "We do have a lot of foreign patients who can't provide us with their specific information to show us they are legal in the United States." Beth said, "I think one of the big ones [barriers] is the fact that they can't prove they're legal citizens. Which does mean that they're not entitled to insurance and they're not entitled to services at a discount." Though not even all legal citizens can produce these documents, Beth repeated the word, "entitled," reflecting the national mentality that Latino immigrants are less deserving of care. While the number of Latinos using Olde Towne services is on the rise, Kathy believed she noticed a reduction in Latino immigrant patients "because of the policies." When discussing the Spanish classes Olde Towne providers took in the past, Kathy explained:

And then all of the sudden we quit doing it but it was because of the change, or really not so much of the change as a following of policy that if the immigrants were not here legally, they

were not eligible for sliding scale because they therefore were not residents, which has created, they don't come in for routine care and routine follow-ups because they can't afford it. And I think here in this community, that enforcement of that policy is what, is the biggest of barriers to care

Though Kathy acknowledged the barrier the new documentation policy creates for Latinos, she did make the mistake of assuming that illegal immigrants "therefore were not residents." There are many extenuating circumstances that could impede a Latino's ability to produce the required verification of residency. Megan observed these issues when setting up appointments for new patients at the reception desk. She explained, "For instance, if they're renting from a friend, that don't have any kind of contract or anything like that." Tonya explained how an extended family's living arrangement can prevent Latinos from possessing the appropriate documentations. She explained that it is not uncommon for a mother and her children to live with the mother's sister and that sister's family. Tonya explained, "The lease is in her sister's name and the electric bill, so even though mom is fully entitled to the services, she has nothing that shows that she actually lives in James City County." Tonya described how gender dynamics may affect mothers. Tonya said, "So if it's mom applying, the services are in dad's name, so mom may not have a driver's license. You know, mom may have nothing that's in her name." Additionally, Tonya recognized the language barrier as a factor that can prevent Latinos from obtaining the necessary documents. Tonya believed another barrier is "mom not having her birth certificate or mom not having the baby's birth certificate because the baby's born and mom doesn't understand, or her English skills aren't good enough for her to understand how to apply for a birth certificate." She continued, "Or she gets some sort of communication from the Department of Health and the process starts in the hospital. Mom gets a letter from the Department of Health that requires some sort of follow up, but she can't read it, so it sorts of slips through the cracks." Tonya recognized the complexity of the system, stating, "So it's just

getting the baby's social security card, getting her birth certificate, because it's hard enough to figure out when you are English-speaking, I think, it's a little confusing to some folks."

Providers recognize that the document requirements prevent Latinos from qualifying for a payment level on the sliding scale, and therefore they cannot afford medical care. This demonstrates how one's immigrant status affects one's health insurance coverage, which is a major determinant regarding whether an individual has access to care. Carl explained, "I think it seems like a lot of our patients who are Latino may not be able to have a level with us. For whatever reason, they are unable to meet all of the requirements to be established as a level... and when that's the case they're not eligible for some of the services that we can provide. So payment is an issue, and billing and then debt; it's an unfortunate cycle." Carl also noticed that Latinos "make their follow-ups less frequent if they were not able to pay." Malia also pointed out that when Latinos are uninsured and cannot afford care, they must rely on home remedies and herbs in place of clinical visits and prescription medications.

In order to provide care for patients who do not qualify for the sliding scale and thus cannot afford medical attention, Olde Towne offers free medical screenings throughout the year. Kathy said, "One thing we have done, because we know the Latinos are not coming in because they're quote 'full-fee' until we can get this changed. We've started doing more free screening days. We do an adult free screening day." She attributed Latinos' financial constraints, due to documentation issues, as the barrier preventing Latinos from utilizing Olde Towne's standard services. Many providers recognize that these screenings bring in more Latinos than any other segment of the population. Carl said, "There are a lot of free screenings that are available for anyone to come in, which I think we have picked up a lot of people who might not have come in

just because they have been afraid to set up an appointment, getting a level with us, or they were afraid of the bill that they were going to have, and so I think that helps.”

Despite efforts such as these free screenings, Latino’s documentation status prevents them from receiving services Olde Towne provides. For example, the Medical Assistance Program (MAP) helps patients receive free or greatly reduced name brand medications from the manufacturer. Olde Towne provides advocates to walk qualified patients through the application process in order to receive their medication. However, MAP does not help all needy patients. Julie described MAP, saying, “The manufacturers almost entirely will not give meds to someone unless there is a documented number. So if it’s not the social security number, then it’s got to be registered alien number.” Julie recalled that during her two years working for MAP, “I haven’t come into the need of an interpreter.” She also explained she has never needed to give a Spanish-translated MAP brochure to a patient because, “if they don’t speak English, they’re usually not registered. If they are not registered either as a registered resident or if they don’t have a social security number or a registered number, I can’t apply for them. So we have not had a patient that that would require a translator.” The manufacturers dictate the requirements to qualify for the program, which demonstrates a common mentality that non-English speakers do not have the necessary documents to qualify for the services that documented, and thus deserving, patients can access. Many providers harbor this notion. Paula described such assumptions while recounting the incident with the Latino man who experiences seizures due to what he believes to be a religious curse. Paula said, “There was the interaction too where someone asked if he had ID and the assumption was no that he probably didn’t. The assumption would be that, well I can’t speak for their assumptions, but at least it seemed like they didn’t think he would have an ID, but in fact he did, and he pulled out his license and showed it.”

Many providers expressed frustration with the new (as of 2006) policy since it limits their ability to help Latino patients. They feel Olde Towne is moving in a different direction, as a less inclusive and less welcoming clinic due to the strict interpretation and enforcement of documentation requirements. When I asked Beth, a nurse practitioner, how she feels OTMC addresses the challenges Latinos face when trying to access healthcare, the following conversation ensued:

Beth: Until, I don't know, a year, year and a half ago, I would have said very well. But when the new federal guidelines came out about assisting Latinos who were illegally in this country, our Board took a pretty hard stand on that. And so therefore, many of the persons who were getting discounted services here no longer qualified. And so, in that sense I don't think we are helping. We help the ones we can. And we help the ones by offering free services...But you look at what's going on in our country as far as illegal aliens and funding, you understand why people get, are anxious. I mean you don't receive federal funds, to quote unquote run the clinic, but we do get federal funds from insurances.

Kim: So did this decision a year, year and a half ago, it changed what documentation you had to show in order to qualify for the sliding scale?

Beth: Mhmm.

Kim: And where did that change come from?

Beth: From the Board.

Kim: The Board of?

Beth: Olde Towne. It was based on their interpretation of what the federal mandates were.

Kim: So the Board of Directors?

Beth: Mhmm. (pause) You know, they were interpreting that federal mandate.

Kim: So is there anything you would do to change the services or the resources provided to Latino patients, if you could change?

Beth: Well, obviously, I'd like everybody to be available to get the same discount, regardless of what their nationality is or your legal status or whatever. We also, operate under the fact that we only give discounts to people who are in our jurisdiction, you know, like James City County, Williamsburg, and York County, so even that in itself is restrictive...We can serve anybody for full fee (laughs).

Beth explained that Olde Towne no longer helps undocumented Latinos. She addressed the issue on a national level, alluding to the anxiety agencies feel when trying to balance the needs of Latinos while simultaneously staying out of trouble and "protecting us government wise," as Megan put it. Beth illustrated how patient registration protocol reflects Olde Towne's Board of Directors' interpretation of the new Medicaid Citizenship Documentation Requirements

provision. Some providers express their desire for a change in protocol, wanting documentation requirement to return to how they were prior to July 2006. Kathy said, “I would like to see us be more aggressive with lowering and allowing them sliding scale, payment wise... I would like to make the sliding scale more user friendly for them, or they could be accepted for sliding scale if they were quote undocumented.”

Who is the (Deserving) “Community?”

The providers refer to the Latino population as a separate and homogeneous community, existing apart from but also inside of the larger Williamsburg community or the United States as a whole. These providers perceive the Latino community to be a separate entity. Restrictive eligibility requirements create the impression that Latinos are undeserving “others.” The language that healthcare and service providers use demonstrate this “othering,” which has adverse effects for Latinos.

Latinos suffer when public anxiety regarding legality influences policy and protocol.

Doctor Greg illustrated the power of perception:

It’s just the cultural perception, but becomes a challenge when people perceive that they’re not a contributor to the tax base, and I’m not saying that they’re not, but this is the perception that, the perception of some people in the US are that these people are free loading, taking advantage, not paying taxes but then expect services, and in fact not only services, but we have to go the extra mile because there are these cultural and language barriers that provide an extra amount of services.

Greg demonstrated how the public may view Latinos as undeserving of care, especially specific services. He explained that in order to combat such animosity, the public needs to understand how Latinos contribute to the economy. Furthermore, Greg believed that providers will have an easier time helping Latinos if this negative perception did not persist, eliminating a major barrier to care:

So part of that I think is a battle at the heart and mind of American society, which is first of all, realizing what is realistic immigration policy and understanding that these individuals play a very important role in our economy. Without them we all would be in trouble, and so maybe changing some of those policies would help minimize that... first if you can address that, your job becomes a little bit easier because then you change the basic way people are looking at the problem and you don't have a barrier in people's minds to why we shouldn't. They're initially coming to the table with an assumption that we shouldn't provide the care because of they're here illegally or they're not paying taxes, well show that we have a need for them, maybe we should make them legal.

Greg went on to explain that he believes that Latinos do pay taxes, contribute to the workforce, and are "vital to our economy." He feels effective change must also come from the federal level, "with more reasonable immigration policy and then maybe some advocacy from different organizations." Greg concluded:

But once you've addressed that, then you can do that also inside your local community, but too, so if you can get over those false assumptions and maybe get some more reasonable federal and local policies regarded to some of these populations, and then people will see the inherent value in having them in you community, then it becomes easier then to justify, well yeah there is a small extra expense to properly take care of this patient population but this is why it is so vital.

There are efforts to address the negative perception of Latinos in Williamsburg. Peter said, "I know there's efforts that occur within the Williamsburg community to put information out there for people to have a better understanding of a particular minority population." Malia explained that the Network for Latino People is trying to educate the entire community about the Latinos in Williamsburg, providing information regarding why Latinos come to Williamsburg and what they do once they get here. Malia said the Latino Network is trying to "combat the very public perception that if you are here in Williamsburg and you don't speak English, that you are illegal." However, she believed, "I don't think that we have been real successful in that." Cindy noticed this negative public perception in regards to ESL classes. She said, "There is a lot of prejudice against international, non-Americans, so in that respect ESL classes tend to be

marginalized because when push comes to shove are you going to spend money on American citizens or people that may or may not be legal. They are going to choose the American citizen.”

The language that providers use seems to reinforce this “otherness” projected on Latinos, expressing that Latino immigrants are not part of “our” community. Natalie consistently used expressions such as, “their own community” or “our own citizens.” She compared “our own patients” to Latinos. When discussing the need for Latino immigrants to learn English, Natalie said the “push” needs to come from “both the Hispanics and our population... Both sides. We need to reinforce it. They need to provide it and vice versa.”

Natalie and registered nurse Kelly group Latinos as a separate entity and a standard in which to compare the rest of the population. Kelly said, “We have some patients who are just as bad off as Latinos.” Natalie compared, “Our citizens of that, what’s the word I want to use, of that nature or whatever, have that same problem...Most of them [Latinos], some of them are doing a lot better than our own citizens.” Kelly compared Latinos’ living arrangements “versus the Americans.” While she acknowledged the barriers to care Latinos face, Kelly continued to make comparison, saying, “I think a lot of them are illegal. They don’t have the income; they know they can’t afford to pay, so therefore, they’ll like I imagine like at the OB clinic for a good example, versus the Latinos and the Americans here. We come in much earlier for prenatal care versus their culture.” By pitting “Latino” and “American” against each other in a comparison, Kelly uses language that insinuates that Latinos cannot simultaneously be “Americans.” This language contributes to the stereotype that Latinos are illegal, “non-American” others, who are therefore less deserving of care.

Tonya described commendable efforts to help Latino. She said, “We invited people from the community to come talk about their interactions with the Latino community and what we

thought some of the barriers were and how we might be able to address them.” Though her intentions are to help Latinos and eliminate barriers, Tonya’s reference to “the community” versus the “Latino community” creates a separation between these two imagined, distinct communities. Such language implies that the Latino community is not a part of *The Community*, and “a society that is unwilling to ‘imagine’ undocumented settlers as part of the existing society places limits on their incorporation” (Chavez 1991: 262).

Carl acknowledged the need to pause and look at who “the community” actually refers to, and consists of, in order to serve all members living in the area. As opposed to other providers who distance the Latino population, Carl recognized the importance of embracing the diversity of the community and thus the diversity of the health needs within the community. He believed this is necessary in order to keep the community healthy:

The goal is to take care of the health needs of the community. From our prospective, we’re working to addressing the health needs of the community, that’s why we’re here. And part of our community are people who don’t speak English, and part of our community is the Latino population, so from our perspective, I guess, to meet the health needs of the community, you have to figure out who your community is and you have to do what it takes to meet those needs. You don’t get to necessarily choose your community. I guess that’s how they’re justified to me, is that that’s who we’re here to serve and I don’t know if you’re supposed to say, “Well you’re harder to serve, you’re harder to care for, so we’re not going to.” It just means that you have to work harder to serve them, or you have to find other ways to do it, and you still want to be efficient, but I don’t think you get to cop out.

While it is vital to recognize differences, in order to provide appropriate services or resources to address these differences, Latinos’ distinct cultures and needs should not result in their exclusion from “the community.” Chavez (1991, 2008) describes how Latino/a immigrants’ cultural differences and documentation status may prevent their complete incorporation into their new society; and therefore, the Latino/a immigrants become “outsiders.”

Perceptions of Patient Compliance and “Othering”

The medical and services providers have mixed feelings regarding the compliance of their Latino patients. While some feel that their patients’ lack of compliance is to blame for poor health outcomes, other providers believe that while it is clear that Latinos do have barriers preventing them from following all recommendations, they make great efforts to follow medical advice. By removing blame from the medical system or the providers and placing it on the individual patients, it is easier for providers to assume that they are doing everything in their power to help. Peter explained:

Sometimes one can’t ensure that the patient is going to be compliant in their treatment and do what they should do. You know, lose the extra weight or give themselves an insulin shot when they’re supposed to, don’t eat that extra piece of cake. That’s just part of human nature regardless of an individual’s culture, so one way we try to deal with a lot of those issues is through patient education.

Natalie explained that failed health outcomes are often the result of patient defiance and non-cooperation:

Sometimes when it doesn’t work it’s not always the providers, sometimes it’s compliance from the patient. ...And it’s kind of the old mantra, you can lead the horse to water but you can’t make him drink. And so sometimes you can drive these things home, but they don’t come back always for their check ups like they should. They might have another problem and then sometimes the problem is out of control and so forth. So I would say, the system from where I see that doesn’t work is from our perspective right now is more patient compliance.

Julie explained that she has patients who will discontinue their medications. She said, “I’ve had patients go off their hypertension meds, really bad things. You can’t do that. When they do that, you try to bring them in and you try not to chide them or scold them, but you need to explain to them how important this is to their health that you really need the continuity.” Beth agreed; she does not believe she can ensure adequate care for all patients because the patients may not follow her recommendations. She said:

I'm not sure you can ensure it. I mean, you can do what you can do here. You can write the scripts, but if they don't ever get them filled. If they don't ever contact or go to physical therapy or you know what I'm saying. You can order things, but it doesn't mean it's going to be done.

Natalie is frustrated by the high rate of “no shows,” patients who make appointments and fail to attend. She acknowledged that they may have issues with childcare or work commitments. She said, “I'm not always saying they just don't comply because they just don't comply...But if they communicate that to us, for example, when they call for appointment, we always try to give them an appointment when we know we have a translator here.” She shifted the blame away from the healthcare system and onto the individual patients:

I've been in the medical profession for forty years, and I really am convinced that our healthcare is not as bad as the media and the public think it is. It really isn't. There are resources, there are things, it's just people knowing where to go, where to do it, and people doing it...my biggest problem was just getting patient compliance...And these people are included in the statistics out there about people not getting treated. And so I just think that it's not as bad as it seems. I think if we could get people to comply a little better.

Natalie believed more people could potentially have health insurance, which would reduce the number of people who go without medical care. She explained, “There's a lot of people out there that could have insurance. They don't want it. They don't want to pay for it. And all these people are included in this huge number of what we think are people out there suffering, not getting healthcare, and that's just not always the case. And these things are overlooked.”

Despite some providers' belief that Latino patients are not compliant, others express varying views. Doctor Greg described the respect his Latino patients show towards all medical professionals. He believes they are very receptive and take medical advice “very seriously and want to follow that advice, which is something we call compliance.” Greg continued, “They do respect what medical providers say and do want to follow through with that, so that's helpful.” Compared to health providers who complain that their patients fail to do as they say, Greg believes in working together with his patients and “not being paternalistic in medicine.” He said

the medical treatment of patients is “a partnership, so there’s two-way communication going back and forth and not just a doctor telling a patient this is the way it’s going to be.”

Though some providers are frustrated when patients do not pick up their medications or continue to take the drugs regularly, Kathy understands that these patients are not simply ignoring physician recommendations. Due to her working-class upbringing, Kathy can understand the economic hardships that can prevent patients from purchasing and refilling prescriptions. She said, “I can understand a medicine only costing five dollars and a parent can’t afford it because it wasn’t planned; you know, their living very close to the mark.” Kathy continued, “I understand that. I’ve been there. And I think it’s very hard for some people to understand why someone can’t come up with five dollars. And it’s three days until payday.” While some physicians cannot empathize with patients in this position and attribute poor health outcomes to the patients’ lack of compliance, Kathy relates to the economic burden medicine has on the lower class, including undocumented Latino immigrants who do not qualify for assistance.

We Do What We Can

Though the providers whom I interviewed “have a heart for this population,” over time they have come to accept many of the barriers that their patients face. Doctor Greg said, “It seems to work reasonably well...But again with limited resources and limited time, you do the best you can.” Kelly said, “It’s working right now, but there’s always room for improvement.” Peter remarks, “There’s always opportunities for improvement. I can’t say that we meet everyone’s needs, but we do what we can. And there’s always going to be opportunities for improvement.” As a top administrator of a clinic created to help the underserved, Peter acknowledged that Olde Towne does not meet everyone’s needs.

Despite a desire to help this needy population, providers fall back on “we do what we can” to justify those in need who Olde Towne does not help. When asked if she would change anything about the services or resources Olde Towne provides, Natalie answered, “Not really because I think we’re doing the very best we can.” Greg described Olde Towne’s staff as “pragmatic but passionate.” He believes that the staff embraces “the mission of providing healthcare to anyone who needs it and can’t afford it.” He explained that the providers understand the social and political barriers to care, “but we have to do the best we can to work within those constraints but still provide the highest quality access to care that we can.” Despite recognizing and working with and around the barriers, Greg felt that “you can’t be all to everybody and you do the best you can under the circumstances, and where you can’t control them, then you give that up to God and that’s about all you can do.” He acknowledged that it is hard for providers to see patients struggle when “you wish you could just take care of them.” Despite this frustration, he decided, “I think we do a good job trying to, despite that barrier, work with the patients the best we can.... we do the best we can to give access to everyone we possibly can, and that affects even the Latino population.”

Carl acknowledged that providers may need to think outside of themselves to understand barriers. He believes providers may not be cognizant of all the issues plaguing their Latino patients. Carl thought, “maybe even having a kind of a cultural competency class every once in a while just so we are more aware of the barriers that exist that we might not even be aware of” could help improve the quality of care providers give their Latino patients. However, it is vital to reexamine constantly the methods used to promote better care for Latinos. Tonya described cultural competency training as “part of our institutional history...It’s like brushing your teeth; it’s just how it is.” Though cultural competency training is helpful in theory and has the

potential to be extremely beneficial to Latino patients, it is important to consistently reevaluate effectiveness and search for issues that providers may have never noticed or understood in the past. Carl suggested, “Even having something like a survey that would more directly question the patients of the Latino population how they feel that those needs are being met.” He believed this survey “would let us even know what kind of needs, places where we are having problems, where we’re not meeting their needs, or they feel like we’re failing in the cultural competency department, so that we are more aware of the places that we’re not doing well.” Carl acknowledged that when going through the motions, providing services that the staff believes are helpful, there is the potential for missing the mark on an important issue that greatly affects the care Latinos receive. Carl stated:

I think it’s easy to kind of think that everything is going okay and if you’re not getting a lot of obvious negative feedback, then you don’t realize the places where you are having problems. I think sometimes it’s easy to think that just because you are making services available, that you’re meeting the needs of that population, but that’s not the case necessarily...there may be some other needs that they have that we don’t realize...there may some things...that we don’t even think about because it wouldn’t occur to us.

Hence, there is a need to examine the quality and effectiveness of services – such as volunteer interpreters – to ensure that these services are providing the best possible care for Latino patients.

Part Four: Analysis and Conclusions

During my research, I met many good-hearted, hard working individuals. These healthcare and service providers have good intentions; they want to help their patients. Though these professionals could work in the private industry where they would earn higher salaries, they unanimously agree that they enjoy the non-profit world and find their work gratifying. They express a moral and ethical responsibility to help the underserved. As Deeb-Sossa (2007) describes from her work with the staff of a community health clinic in North Carolina, “They were good people because they cared for those they saw as the most oppressed (Deeb-Sossa 2007: 770). The service and healthcare providers I interviewed are also good people, and I can imagine myself working for similar service organizations in the future.

Regardless of the providers’ noble intentions, Latinos are not getting the appropriate quality care that all people deserve. The institutions that shape the quality and dynamics of service provision are larger than the individual providers. The institutions constrain the providers’ actions and dictate how they do their jobs. Furthermore, institutions enforce “borders” of entitlement through the application of increasingly restrictive immigration policies and eligibility requirements, which contribute to the construction of otherness (Deeb-Sossa and Bickham Mendez 2008: 617). For example, eligibility policy restrictions, passed at the federal and state levels and interpreted by the Olde Towne Board of Directors, determine which patients make it from the waiting room back to see a physician.

Many providers convey their frustrations with the eligibility requirements that prevent them from serving all patients in need. In addition to the legal barriers, the providers recognize cultural differences that affect the care they provide for Latino patients and the health outcomes of these patients. However, a dominant theme in the interviews was a quality of “sameness.”

Interviewees express a philosophy that they are responsible for treating everyone the same. The providers serve a diverse population of patients who society has historically marginalized and discriminated. The providers serve the undeserved – the poor, the unemployed, single mothers, Blacks, as well as Latinos – and are aware of the prejudices that have impeded these groups from attaining quality care throughout history. Therefore, they explain their actions based on the idea that “everyone is the same” with the belief that this will ensure quality treatment for all patients.

Ironically, most interviewees also acknowledge that their Latino patients are *not* the same as their other patients. Latinos have specific needs that require specific attention. Their different needs mean they need specific resources and services. Herein lies the problem. Providers notice the diversity among their patients, yet providers claim that all patients have the same problems, and therefore providers must treat everyone the same. This disjuncture affects the quality of care that Latinos receive.

Thus, despite an articulated view that “sameness” will ensure equal treatment, healthcare and service providers contribute to the “othering” of Latinos. Though they do not make a conscious effort to exclude Latinos, their language does not foster a sense of inclusion for Latino/a patients into the larger community, and thus, “progressive people fail to notice how they inadvertently reinforce the inequalities in their midst” (Deeb-Sossa 2007: 770). When they describe “the community,” the providers are not referring to Latino immigrants. They create distinct categories, which develop as opposite binary pairs, such as “documented” versus “undocumented.” Many providers carry the assumption that *we* are enablers, allowing Latino immigrants to continue using Spanish. (*They* should encourage *their community* to learn English, while *we* should promote it, as well.) This “us” versus “them” language separates Latinos into a different category. They are not one of “us,” not American. This lack of

“American-ness” turns Latino immigrants into the undeserving “other.” Their use of language to construct categories of belonging is reminiscent of Chavez’s work (2008). He notes that “the terms in these binaries are not equal but exist in a power relationship such that one term is dominant and the other subordinate, one positive and one negative, one normal and one pathological” (Chavez 2008: 128).

Furthermore, immigration status has a profound impact on the “othering” of Latinos. Documentation is a symbol of social membership, and “undocumented immigrants exist as marginal persons, as outsiders” (Chavez 1991:263). Without it, patients do not qualify for the sliding scale at Olde Towne and thereby cannot afford to pay for medical treatment. Consequently, “the immigrants’ legal status determines whether they will have access to nonemergency formal medical care; the ‘choices’ for the undocumented are quite limited” (Menjívar 2002: 458). A lack of required documents means that needy patients become invisible. As noted by De Genova (2002), “‘Illegality,’ then, both theoretically and practically, is a social relation that is fundamentally inseparable from citizenship” (422).

Healthcare and service providers need to reexamine and reevaluate the effectiveness of the services they provide for their Latino patients. For example, though Olde Towne prides itself on its interpreters, they are not always available. Often these interpreters are untrained and could hinder the patient with limited English from receiving quality care. Untrained and unavailable interpreters demonstrate how, in order to provide the best care for patients, providers must not settle for the current resources that are in place. On the contrary, providers have the responsibility to question the current system and look for ways to address barriers and employ resources in a way that promotes the highest quality of care for all patients.

Many providers fall into the trap of accepting barriers and inequalities as just the way things are when working with an underserved population. They demonstrate a “we’re-doing-the-best-we-can” mentality. They understand the legal barriers, such as documentation, that are out of their hands. Additionally, many point to patient noncompliance as the source of problems. However, healthcare and service providers do not stop to consider how their own assumptions affect the care they administer to patients. Media imagery and societal attitudes shape providers’ impressions of “Latino-ness.” Therefore, they bring a set of preconceived notions to work with them each day. Their idea of what it means to “be Latino” affects their perceptions regarding barriers and patients’ needs. These perceptions then affect providers’ practices and treatment of patients in the office encounter.

Healthcare and service providers are in a position of power because their belief system affects the care of their patients. The providers’ perceptions of their Latino/a patients demonstrate the ways in which their interpretations and practices can contribute to “the construction of otherness and the enforcement of definitions of insiderness and outsiderhood” (Deeb-Sossa and Bickham Mendez 2008: 632).

When providers view their Latino patients as members of a different community, separate from their own, these Latinos become excluded. Thus, they do not receive the social benefits of inclusion, including medical care at reduced rates. The United States excludes Latino/a immigrants from the community because they are “non-citizens.” According to Chavez (1991), “Until the larger society imagines them as part of the community, they will remain marginal; they will be outsiders continually seeking an end to their liminal status” (Chavez 1991: 274).

While service and healthcare providers’ assumptions and perceptions of “Latino-ness” influence the quality of care their Latino/a patients receive, the power lies in the institutions that

dictate who is eligible for services. Federal and state policy makers construct “illegality.”

Healthcare administration then determines how to interpret the policy and apply the law to the specific clinics. Therefore, these institutions have the power to marginalize groups of people and perpetuate systems of inequality.

Thus, the institutions have the greatest capacity to bring about change. Administrations could interpret policy, such as the Medicaid Citizenship Documentation Requirements provision, to allow for more lenient eligibility requirements that take into account the documentation issues that Latino immigrants face. Tolerant eligibility requirements will make healthcare more affordable and, thus, more accessible to Latino immigrants. Simultaneously, lenient interpretations of federal and state policy will make the clinic a more welcoming place for Latino immigrants, thereby removing the stigma that Latino immigrants are undeserving of social and healthcare services while in the United States.

Though it is plagued with a history of inequality and racism, the United States prides itself on its democratic values. In order to represent a truly just and inclusive society, policy makers and the public alike must reexamine the concept of health as a social right and accept that all people deserve the opportunity to prevent illness and maintain their health. To deny this right violates social justice, thereby promoting inequality and exclusion.

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Appendix A: Interviewee Information

Interviews at Olde Towne Medical Center

Beth, a nurse practitioner in the clinic and in the van, is a white woman in her forties or fifties.

Carl, a physician's assistant, is a white man in his late twenties or early thirties.

Greg, a doctor and medical director, is a white man in his early forties.

Helen, a clinical secretary, is a white woman in her fifties.

Julie, a program director, is a white woman in her fifties.

Kathy, a nurse practitioner, is a white woman in her late fifties.

Kelly, a registered nurse, is an African American woman in her forties or fifties.

Megan, a white woman in her twenties, works in medical records and at the receptionist desk

Natalie, a volunteer coordinator and volunteer nurse, is a white woman in her sixties.

Peter, a top administrator, is a white man in his sixties with a bachelor's degree in business administration and a master's degree in public administration.

Interviews at the Rita Welsh Adult Literacy Program

Cindy, an ESL instruction manager and Rita Welsh program coordinator, is a white woman in her forties with a master's degree in linguistics.

Paula, a director at the Rita Welsh Adult Literacy Program, is a white woman in her thirties or forties.

Interviews at Child Development Resources

Malia, a director at Child Development Resources who works with the Network for Latino People, is a Latina woman in her thirties originally from Columbia.

Tonya, deputy director at Child Development Resources, is a white woman in her late forties or early fifties.