A R T I C L E

RACISM IN ORGANIZATIONS: THE CASE OF A COUNTY PUBLIC HEALTH DEPARTMENT

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Racism is part of the foundation of U.S. society and institutions, yet few studies in community psychology or organizational studies have examined how racism affects organizations. This paper proposes a conceptual framework of institutional racism, which describes how, in spite of professional standards and ethics, racism functions within organizations to adversely affect the quality of services, the organizational climate, and staff job satisfaction and morale. Grounded in systems theory and organizational empowerment, the framework is based on data that describe how racism was made manifest in a county public health department. The findings highlight the importance of understanding how organizations are influenced by external forces and can negatively affect clients, communities, and their own staff members. © 2007 Wiley Periodicals, Inc.

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In the United States, despite changes in laws governing the treatment of oppressed racial and ethnic groups over the years, the deep structure forming the undemocratic foundation of the United States has not been fundamentally altered (Marable, 2002). The privileges and power associated with "whiteness" and the disadvantages associated with "color" continue to endure and adapt over time (Aspen Institute, 2004). Although racism is incongruent with democratic ideals, both are pillars of U.S. society and American culture (James, 2003). African Americans and other People of Color (Latinos, Asian/Pacific Islanders, and Native Americans) have received inferior treatment across a range of American societal institutions, including health care, largely because these institutions are not immune to deeply rooted societal inequalities (Smedley, Stith, & Nelson, 2003; Trubek & Das, 2003; Williams & Rucker, 2000). The Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,* illustrates how the social hierarchy that exists in society plays an important role in explaining differences in the quality of care provided to People of Color in the United States (Smedley et al., 2003).

Whether public or private, organizations are rooted in the same systematic inequalities as the rest of U.S. societal institutions. Consequently, organizations, often unintentionally, function as tools of oppression, reproducing and reinforcing the very marginalization that some are committed to undoing (Adams & Balfour, 2004). By serving as conduits to resources and providers of critical services, organizations can have the capacity to impede a community's power, agency, and ability to access resources and services (Morgan, 1997). At the same time, because they are interconnected to their sociopolitical contexts through funding streams, government mandates, and the practices of individual staff members (Trubek & Das, 2003), organizations are influenced by societal institutions and forces. In the body of research on organizations within community psychology and organizational studies (Boyd & Angelique, 2002), few studies acknowledge the sociopolitical context of organizations or examine the role that organizations play in promoting racism and other forms of oppression.

This paper describes the efforts of one county public health department in the rural South to examine how racism is manifested in its organization and in the services it provides. We begin by synthesizing work in community psychology and public health to define and characterize the concepts of oppression and racism. We propose a conceptual framework of institutional racism, illustrating how racism permeates a health service organization (e.g., the quality of health care provided, the organizational climate, and individual staff members). Then, we draw on systems theory to apply the concept, *administrative evil,* as a mechanism by which racism can affect the quality of health services. Finally, we apply the model of institutional racism to our study, which examines how racism is made manifest in a county public health department.

RACISM

There is a strong and consistent literature that attests to the persistence and prevalence of racism, racial prejudice, and racial discrimination in contemporary U.S. society (Byrd & Clayton, 2000; Feagin, 2000; Feagin & McKinney, 2003; Feagin, Vera, & Batur, 2001; Geiger, 2003; Polednak, 1997; Steinhorn & Diggs-Brown, 1999). Racism, because it is a form of oppression, can be characterized as both a process and an outcome (Watts, Griffith, & Abdul-Adil, 1999). As a process, racism has been defined as "an organized system, rooted in an ideology of inferiority that categorizes, ranks, and differentially allocates societal resources to human population groups" (Williams & Rucker, 2000, p. 76). As an

outcome, racism has been described as the product of long-term, consistent economic, social, and political inequity based on race (Watts et al., 1999). This distinction is useful in explaining why, for example, Black Americans continue to lag behind Whites on almost every measure of prosperity (i.e., employment, criminal justice, economic resources, health, and education; Pettigrew, 2004). Also, this description of racism is useful in explaining the experiences of other People of Color who are similarly socially oppressed.

In addition to racism, ethnic discrimination and oppression are common in the United States (Contrada & Ashmore, 1999; Contrada et al., 2000; Perreault & Bourhis, 1999). Because discrimination based on ethnicity shares so many similarities with racism, we will use the term *racism* to characterize the common social, political, and historical oppression of People of Color. *Race* is defined, therefore, as a social category that precisely captures the impact of racism and differential access to power and desired resources in society, rather than a biological construct that reflects innate differences (Jones, 2000; Williams & Rucker, 2000). People who experience oppression because of their ethnicity may or may not be of the same race, or race may be a less central aspect of their identity. Ethnicity, or the common worldview, language, and behaviors associated with a cultural heritage (McMahon & Watts, 2002), may be more salient for them, despite their similarities with other People of Color. Regardless, the experiences of racism for People of Color share more commonalities than differences. However, Whites and People of Color have widely divergent views of the definition and prevalence of racial and ethnic discrimination (Smedley et al., 2003). People of Color "not only perceive more discrimination, they also see it as more 'institutional' in character . . . whereas many Whites tend to think of discrimination as either mainly a historical legacy of the past or as the idiosyncratic behavior of the isolated bigot" (Smedley et al., p. 94).

INSTITUTIONAL RACISM

Institutional racism is a systematic set of patterns, procedures, practices, and policies that operate within institutions so as to consistently penalize, disadvantage, and exploit individuals who are members of non-White groups (Better, 2002; Rodriguez, 1987). Researchers in this area find that institutional racism includes organizational procedures such as hiring, promotion, and evaluation; affects recruitment and promotion, institutional policies, and organizational climate; and may function at three distinct levels within institutions: attitudes and action of personnel, policies and practices, and structures and foundations (Barndt, 1991; Chesler & Delgado, 1987; Watts & Carter, 1991). Building on this literature on institutional racism and a model of organizational empowerment (Peterson & Zimmerman, 2004; Zimmerman, 2000), we argue that institutional racism operates at three levels of an organization: the individual level, the intraorganizational level, and the extraorganizational level.

Institutional racism explains how oppression can permeate different organizational characteristics and dimensions. At the individual level, racism operates through staff members' attitudes, beliefs, and behaviors. At the intraorganizational level, institutional racism operates through an organization's internal climate, policies, and procedures. These include the relationships among staff, which are rooted in formal and informal hierarchies and power relationships. At the extraorganizational level, institutional racism explains how organizations influence communities, public policies, and institutions. Also, institutional racism describes how organizations are affected by larger institutions (i.e., regulatory, economic, political, professional) and are shaped by the sociopolitical and economic contexts that frame an organization's policies, procedures, and functioning.

Just as organizations can be empowering and promote psychological empowerment, or be empowered and influence the larger system of which they are a part (Peterson & Zimmerman, 2004; Zimmerman, 2000), organizations also can be oppressive. At the intraorganizational and individual levels, organizations can decrease psychological empowerment and promote powerlessness among staff and clients. Because it is so highly individualized and contextually layered and embedded, psychological empowerment is difficult for organizational leadership to promote among staff (Foster-Fishman, Salem, Chibnall, Legler, & Yapchai, 1998). Maton and Salem (1995) conducted a study of empowering organizations and found that their common characteristics were: a strength-based culture of growth, opportunities for multiple meaningful roles, a positive peer-based support system, and inspiring and talented leadership. Arguably, the converse of these characteristics would promote intraorganizational oppression. Finally, at the extraorganizational level, organizations can be instruments of domination (Morgan, 1997), limiting the viability and sustainability of other organizations and the communities that they serve by controlling their access to resources, opportunities, and services. However, because organizations function in the context of external structures and local, state, and federal institutions and politics, their authority and power are limited (Bowditch & Buono, 2001; Dooley, 1997).

Organizational Systems Theory

Systems theory describes how organizational structures and functions interact with the external environment and are influenced by external forces (Bowditch & Buono, 2001; Dooley, 1997). In the context of institutional racism, systems theory describes how organizations can be oppressive and oppressed and how the levels of an organizational structure interact with one another. Organizational structures include the "subunits or subsystems that continually interact and are mutually dependent on one another. Actions that occur within one part of the system not only affect that particular unit but can have a 'ripple effect' through other organizational subsystems as well" (Bowditch & Buono, 2001, p. 17). "'External' or environmental factors not only constrain and influence organizations and their participants; they also infiltrate, construct, and empower them. On the other hand, organizations and participants are not the passive pawns of external events, allowing external forces to freely reshape them, but take steps to control, modify, and challenge these forces" (Scott, Ruef, Mendel, & Caronna, 2000, p. 64). External factors, including the material-resource environment and the institutional environment, can influence the organization in critical ways (Scott et al., 2000). The material-resource environment refers to factors affecting the ability of an organization to produce services, while the institutional environment includes "the cultural belief systems, normative frameworks, and regulatory systems that provide meaning and stability to a sector" (Scott et al., 2000, p. 3). Thus, in systems theory, behaviors, structures, and external influences are not "good" or "bad," but are evaluated based on functionality: the extent to which an event reinforces or challenges the system (Bowditch & Buono, 2001). However, organizational systems can perpetuate racism and other forms of oppression; thus, they are not value neutral, regardless of the intention. A construct that explores this in depth is administrative evil.

Administrative Evil

Adams and Balfour (2004) described the notion that people can act in ways that are harmful to others without being aware of the negative effect they have on them as *administrative*

evil. "Since administrative evil wears many masks, it is entirely possible to adhere to the tenets of public service and professional ethics and participate in even a great evil and not be aware of it until it is too late (or perhaps not at all)" (Adams & Balfour, 2004, p. 11). This concept was conceived by examining the genocide perpetrated by Nazi Germany during the 1940s. This indescribably horrific event was "successful" because of the participation of ordinary German citizens who fulfilled their "morally neutral" professional roles and acted in socially normal and appropriate manners (Adams & Balfour, 2004; Arendt, 1963).

Organizational dynamics can escalate the chances of injurious outcomes, regardless of intention to harm (Adams & Balfour, 2004). For example, the fragmentation of power that is common in modern health care organizations limits their ability to solve problems. The "narrow knowledge" that is the result of training people to play limited roles stifles innovation within the health care system and other modern organizations (Adams & Balfour, 2004; Trubek & Das, 2003). In addition, when an organization has significantly "sunk costs" into a particular approach or trajectory, only clear and overwhelming evidence will convince the organization to change course, whereas continuing on a particular course requires no action at all (Adams & Balfour, 2004). The longer a problem persists, the more difficult it becomes to acknowledge, and the harder it is to change (Adams & Balfour, 2004).

Furthermore, when a problem is identified, organizational culture, management philosophy, and organizational values can significantly affect whether people are willing to address or ignore the issue. Morgan (1997) describes organizations as political systems in which employees' desire to exercise their democratic rights may conflict with their role as an employee, since one's dissenting voice, perspective, or ideas can be welcome in some decisions and particularly undesirable in others. Further, the tendency of organizations to decrease sense of power and respect among members can make reporting problems less likely and camouflaging mistakes more common (Adams & Balfour, 2004). Also, *perspective* is a critical aspect of administrative evil. There is often a discrepancy or "magnitude gap" between the perpetrator and victim's perspectives and emotional reactions to harm (Adams & Balfour, 2004). In the context of institutional racism and health care, different perspectives could be based on one's relative position or job in an organizational hierarchy or the power a provider has over a patient. These aspects of administrative evil influence the quality of health care patients receive and whether that care is different because of their race, ethnicity, or other demographic factors.

HEALTH CARE DISPARITIES

Historically, the U.S. health care system has not provided equitable care to all of its clients (Trubek & Das, 2003). In part, this is because health professionals are influenced by the same social forces as the rest of U.S. society (Smedley et al., 2003). After reviewing a national sample of over 100 studies from a 10-year period, the Institute of Medicine (2003) found ". . . racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention" (Smedley et al., 2003, pp. 3–4). The Unequal Treatment report authors explain *health care disparities* by indicating that these differences occur in the context of historical and contemporary social inequalities, and they are affected by a variety of sources, including stereotyping and prejudice on the part of health care providers, and are not explained by racial and ethnic differences in treatment refusal rates (Smedley et al., 2003).

In addition to health care disparities, within health care organizations social structures of power and privilege are reproduced, negatively affecting job opportunities and job satisfaction for People of Color. For example, People of Color represent a relatively high percentage of low-paid service workers and are underrepresented in health services management (Dreachslin, Weech-Maldonado, & Dansky, 2004). Also, People of Color who hold health care management positions tend to earn lower salaries and report less job satisfaction than their White counterparts (Dreachslin et al., 2004). Further, Dreachslin and colleagues (2004) found that job performance among People of Color was inversely related to exclusion from opportunities for power and integration into the organization. This suggests that increasing opportunities for advancement and to become more incorporated into the formal and informal structures within an organization may be a useful strategy for increasing productivity and job satisfaction. Although the authors note that the impact that placing more People of Color in leadership positions has on eliminating health care disparities is unclear, they conclude, "having an adequate representation of minorities in all levels of the organization is considered pivotal to the provision of culturally appropriate care" (Dreachslin et al., 2004, p. 963).

One critical aspect of health care disparities and a significant barrier to culturally appropriate care is stereotyping. Stereotyping by health care professionals was found to adversely affect decision making regarding health services in the following four ways: (a) limiting the treatment options offered to patients of color; (b) reinforcing negative attitudes toward patients of color; (c) communicating lowered expectations; and (d) decreasing patients of color's expectations for the future (van Ryn & Fu, 2003). Additionally, another study of racial stereotyping among health care professionals reported that although service providers do not express general beliefs about specific People of Color, one member of the Institute of Medicine's Unequal Treatment report committee states, ". . . comments about clients' intelligence, ambition to return to work, and the security of their social situations pop up more often when they explain their decisions regarding minority clients than they do when they explain what they decided to do with White clients" (Gabriel, 2002). Continuing medical education in cultural competence and other training to promote cultural diversity inadvertently encourage generalizations about different racial and ethnic groups that contribute to stereotyping and poorer quality treatment on a case-by-case basis (Gabriel, 2002). These findings suggest racism has permeated the institution of health care.

In sum, the fields of community psychology, organizational studies, and public health are in the beginning stages of understanding the role of racism in organizations, and how public health organizations are contributing to racial and ethnic disparities in health. The research question for this study was: How is racism made manifest in a rural, southern county public health department?

METHODS

Setting

This study took place in a rural county in the southeastern United States. "Southern County" is the pseudonym used for the purposes of this paper to protect the identity of the public health department and county residents, in consideration of the sensitive nature of racism, organizational oppression, and health disparities issues. In Southern County, non-Whites have higher incidence rates than Whites for diabetes mellitus, heart

disease, and prostate cancer, and a higher death rate from all causes (North Carolina State Center for Health Statistics, 2001). In addition to these health disparities, Southern County has experienced dramatic demographic changes in the last two decades. According to the 2000 Census, there were 49,329 residents in Southern County; however, between 1990 and 2000, there was a 741% increase in the Latino population (U.S. Census, 2000), primarily due to immigration from Mexico and Central America to work in the local poultry industry. This significant change in the county population challenged the public health department's capacity to provide culturally appropriate health care. Incidents of overt racism occurred in the community, including a Ku Klux Klan rally (Cuadros, 2000), and clients and staff complained that staff were ill prepared to serve this new population (Appendix A). This increase in the Latino population of Southern County was the impetus for the public health department to begin addressing racism.

The mission of Southern County Public Health Department (SCPHD) is to protect and promote the health of county residents in partnership with the community by pursuing the following five objectives: (a) preventing the spread of diseases, (b) fostering healthy lifestyles, (c) reducing health risks and assuring safe environments, (d) providing or assuring quality health services, and (e) responding to disaster and assisting communities in recovery efforts (SCPHD Director, 2003). The goals of the public health department include: reducing health disparities based upon race, ethnicity, and/or special health needs; increasing cultural competence of the preventive health care delivery system; and increasing community capacity to address priority and emerging health issues (SCPHD Director). The racial and ethnic demographics for health department staff in 2002 reflect those of the county: 71% White, 18% African American, 9% Latino, 1% American Indian, and 1% Asian/Pacific Islander (SCPHD Director). All divisions within the health department have a 50% or higher percentage of staff who are White. Of the health department's seven divisions, five have a 75% or higher percentage of White employees.

The Southern County Public Health Department began a Dismantling Racism (DR) process in October 2001, when it contracted with **Change***work,* organizational consultants who specialize in implementing antiracist interventions. **Change***work*'s DR process includes a two-and-a-half day training, repeated regularly for new staff, and the creation of two caucuses (one for White staff and a second for staff of color) who meet separately with the consultants and then together as a large group on a monthly basis. A "change team" coordinates the DR process, and develops and implements an action plan for dismantling racism. SCPHD's change team is composed of 15 members who represent each caucus, health department administration, and community residents. However, their efforts did not include an evaluation of their progress and effect on manifestations of racial oppression within SCPHD. Thus, the change team contracted with evaluation consultants from a local school of public health to establish a baseline, using as much preexisting data as possible, on manifestations of racial oppression in the health department. The pre-existing data used are described briefly below (see Appendix A for more details).

Data Sets

Between January and May 2001, the health department conducted: (a) an employee survey, (b) focus group interviews with staff, (c) a community survey, (d) a review of health department policies and procedures, and (e) an organizational self-assessment (see

Appendix A). In summer 2003, the change team completed a second review of policies and procedures (see Appendix A). The purpose was to gather information on health department services and race-related issues to inform **Change***work*'s DR process, which began in October 2001, and the DR action plan, which was finalized in January 2004. From August 2002 to September 2003, the evaluation consultants reanalyzed these data to develop a conceptual framework of institutional racism to guide the development of measures for an evaluation of the DR action plan.

RESULTS

For the analysis of secondary data, the study received approval from the school of public health's institutional review board for the protection of human subjects. The change team analyzed each data set separately to identify patterns of racial oppression that influence the SCPHD at three levels: extraorganizational, intraorganizational, and individual. The results for each level are reported below.

Extraorganizational Level

Community survey. Overall, community participants reported having positive opinions of and experiences with the SCPHD, though their more specific responses indicate a more mixed review. Approximately two thirds of Southern County residents believed staff members try to understand their health concerns and the health department is a good place to get help for children or adults. More than half of community participants agreed that it is easy to find a convenient appointment time to receive services from SCPHD. However, what was most telling were two written comments at the end: "There are individuals who work at the Health Department who are knowledgeable, respectful of clients, kind and effective in their delivery of services. However, there were staff who were rude, racist, and ill-prepared to work with the public. The bad experiences, even if few, usually have a more lasting impression than the good experiences." One woman told of a pregnancy test that was not kept confidential.

Focus group interviews. Several themes emerged from the three focus groups that represented patterns of institutional racism at the extraorganizational level. The most pressing theme was the pressure associated with the migration of Latinos to Southern County. Focus group participants described the dramatic changes in the characteristics of the public health department's clientele, and the strain placed on staff resources and skills, and the structures of the organization. Line staff were feeling tremendous pressure from trying to provide services to a population with whom they could not directly communicate, which not only raised concerns about the quality of services they provided, but also the job satisfaction of the staff. Although this was a concern for all staff and leadership, because the direct service providers, receptionists, and other line staff most frequently and directly faced these issues, they were most concerned. Further, line staff were not feeling as though they were being given support or guidance by the organization on how to effectively address this issue. Similarly, staff participants expressed concern that their White and African-American clients were expressing a discomfort with coming to receive services because of the growing Latino clientele.

Perceived racism questionnaire. Ninety percent of staff agreed that their division is actively trying to improve access to services. Ninety percent of White staff versus 75% of

staff of color believed that services are equally accessible to clients of different racial/ethnic groups. Staff who disagreed mostly felt services were unavailable because there were not enough interpreters or bilingual staff. Fifty-five percent of staff of color and only 9% of White staff agreed that the racial climate of Southern County was hostile toward people of color, and about half of the overall staff were unclear if the Board of Health supported the DR process. Finally, staff felt that there was a need for more education on the role of racism in health care, and a desire to make the Board of Health and county commissioners aware of SCPHD's efforts to address these issues.

Intraorganizational Level

Focus group interviews. Another significant issue was the poor communication between the administration and the rest of the staff, and tensions between public health department sites and divisions. A shared concern was the lack of integration among health department services, and poor communication between divisions of the health department, in part, because the organization has two sites in physically different locations. Two divisions had an especially tenuous relationship and perceived a mutual lack of respect, appreciation, and understanding. One of the two was feeling that they had become a port of last resort for clients who were indigent or who lacked medical insurance. This added burden was adversely affecting the organization's internal finances, as they tried to remain under budget, and the organizational climate, as they internalized the negative connotations of being a "dumping ground."

Employee survey. All but two staff either agreed or strongly agreed with the statement, "I believe that a health department that is diverse, integrating people of various cultural, ethnic, political and philosophical backgrounds, is the best way to serve the people of the county," and over 60% agreed that health department leaders model commitment to diversity. On the other hand, half (31) agreed with the statement, "I cannot understand the attitude and behavior of people from different racial, cultural, and economic backgrounds."

Review of organizational policies and procedures. The 2001 review of policies and procedures highlighted a number of problems, some of which were derived from the other assessment tools, while others were new. First, there was a need to increase communication between line staff and leadership. Particularly, this needed to include enhancing line staff's awareness of issues and increasing their role in decision making. The SCPHD created an Employee Council in June 2001 in order to help facilitate progress toward this goal. Next, there was a need for more People of Color in management, as physicians, and as nurses, because there were no nurses or doctors of color, and only one Person of Color in a supervisory position. Also, there was a need to involve more community members in decision making. In addition to these policy and procedural goals, in 2003, the change team highlighted the need to develop processes to address formal and informal charges of insensitivity and discrimination, a protocol to equalize starting salaries and pay raises, and structures to develop leadership among staff.

Organizational self-assessment. In early 2003, the SCPHD director gave a presentation entitled "The State of the Department" that described their demographic trends and services for the most recent five years. Overall, SCPHD clients are 43% White, 33% Hispanic, and 24% African American. This represents a significant increase in services provided to Latinos over the past five years, while services to African Americans decreased over the same period. Whites utilized more than 60% of adult health services, but the total number of women using family planning services was increasingly Latino.

In terms of staff, 87% of all employees were female and 9% were bilingual in Spanish and English. In terms of hiring practices, the fiscal years of 2001 and 2002 showed better distribution of new hires overall by race/ethnicity. However, all new hires in two of the divisions were of White employees. The health director observed that there was a high turnover rate in all areas except administration.

Perceived racism questionnaire. The responses to this questionnaire were analyzed by race, and there was a consistent and significant magnitude gap in perceived racism and fairness. Over 8 out of 10 staff members were very satisfied with their jobs, but in response to whether the respondent believed there was a fair system for all staff to advance to management and supervisory positions, only 55% of White staff and 20% of staff of color agreed. Similarly, 55% of White staff and 30% of staff of color agreed that the health department had made changes to increase the number of applications from qualified People of Color for all job openings. When asked about staff race relations, 93% of staff indicated that race relations in the health department were okay, good, or excellent; however, only White staff indicated they thought relations were excellent (23%) and only staff of color rated it uncomfortable (15%). In addition, over 90% of staff agreed that the health department supported staff leadership and participation in community coalitions and committees, though only half of the staff agreed there was an opportunity for the community to give input into health department programs and services.

Individual Level

Employee survey. A majority (74%) of staff either agreed or strongly agreed that health department staff: have the ability to give good service regardless of racial differences, are aware of prejudice, are comfortable dealing with people of different races and cultures, are comfortable with talking about racial and cultural differences, are able to avoid imposing values that may conflict with other cultural groups, and have no stereotypes of groups from diverse backgrounds. These responses suggest that staff perceived high levels of cultural competence in themselves as individuals. At the same time, the staff agreed that it was important for the health department to hire bilingual staff or recruit trained volunteers to serve as interpreters, as well as to serve people, even if they spoke English poorly or not at all.

When asked to assess their job and organizational satisfaction, over 70% reported being satisfied with the work environment, though 45% disagreed or strongly disagreed that there is a feeling of fairness, cooperation, and mutual respect among staff. One third felt certain divisions were favored and almost 40% reported believing there were cliques or factions among staff. The statement, "Jokes and negative comments about minorities are never heard at the health department," elicited a wide range of responses. Whereas one third of staff participants either disagreed or strongly disagreed (indicating that racial jokes and negative comments are made), over one fourth agreed or strongly agreed.

DISCUSSION

This article presents a broad conceptual framework for understanding how institutional racism was made manifest in a rural, southern county public health department. The framework was based on the concepts of racism, institutional racism, and administrative evil, and rooted in organizational systems and organizational empowerment theories.

The research described in this article highlights one key aspect of systems theory: how the external (social) environment can affect an organization. The evaluation framework was designed to assess, at least qualitatively, how institutional racism is made manifest at three levels of an organization: extraorganizational, intraorganizational, and individual. Though preliminary, our findings suggest that institutional racism was made manifest in each level of the organization. What we do not know is how to quantify the impact of institutional racism at each level, parceling out other potentially interconnected factors (i.e., leadership, professional competence, organizational mandates, political climate). Further, because these factors are so ingrained in U.S. culture, it is difficult to separate factors endemic in the national health care institution from its unique local manifestations, much less teasing apart organizational factors from community context.

At the extraorganizational level, SCPHD was both oppressive and an oppressed organization. Although, generally, county residents felt positive about the organization, they also had negative experiences that undermined some individuals' trust in the organization, and those experiences negatively affected the psychological empowerment of clients. However, what was more evident in the data was how external forces affected the organization. The rapid migration of Latinos to Southern County strained the organization's resources and challenged staff to provide services to a population for which they were unprepared. This challenge had negative implications for staff job satisfaction and, presumably, the quality of care they could provide. In addition, the expressed need to both educate and better understand the Board of Health and Board of Commissioners, who provide local oversight and mandates to the organization, suggests that staff recognize the political aspect of oppression and the power these bodies have over their organization (Bartky, 1990; Gaventa, 1980; Prilleltensky & Gonick, 1996). The magnitude gap in staff members' negative perceptions of the racial climate of Southern County—55% among staff of color versus 9% among White staff—suggests that administrative evil and racism may be occurring throughout Southern County. These findings on the influence of specific forces in the context for staff and clients of SCPHD, arguably, make it critical for the organization to obtain the explicit support of bodies that have power over it.

At the intraorganizational and individual levels, the findings revealed a pattern of administrative evil in the organizational climate and infrastructure (Adams & Balfour, 2004). The poor communication reported among staff generated significant tension between divisions, increased frustration, limited knowledge, and constrained participation in decision making by line staff, staff of color, and community members. Further, findings revealed recognition of the *sunk costs* in a variety of organizational practices and procedures that may have promoted inequalities in salaries, leadership opportunities, and hiring practices. These organizational characteristics translated to narrow knowledge of staff members, heightened fragmentation of power and services, and a high turnover rate in all but one division within the organization.

Between White staff and staff of color, there was a magnitude gap in perceived fairness, belief that there have been organizational efforts to increase staff diversity, and views on SCPHD's commitment to improving the quality of race relations among staff. Independent of race, significant discrepancies were found in staff perceptions of fairness and favoritism, cooperation, mutual respect, and the belief that jokes and negative comments about minorities were ever heard in the organization. Also, staff acted in ways that clients of color characterized as being unintentionally harmful, in that their emotional reactions had an adverse effect on the quality of services they received at the health department. These findings further highlight aspects of administrative evil and psychological oppression, and demonstrate the impact of oppression on both People of Color

and Whites. Although these organizational characteristics may be significantly affecting staff and clients of color, they are clearly affecting White staff as well.

Although this study was successful in describing how institutional racism affected a health service organization, there were several limitations of the study. Because this model of institutional racism was based on a participatory evaluation that relied heavily on data, tools, and methods that could be easily and cost-effectively replicated by staff members, the evaluation team was committed to using the secondary data available. The surveys and focus groups conducted in 2001 had methodological limitations, including many items that did not show any variance and thus were ineffective. The methods used to implement these surveys were not available and were communicated by health department staff who were employed at the time. Due to the low retention rate of health department employees, many members of the change team were recently employed and unfamiliar with previous surveys and focus groups. A health department divisional leader who was a leader on the change team and knowledgeable about the secondary data was interviewed in order to collect information on the methodology. Because this case study examined data from one organization for the purpose of developing this framework, data are not generalizable. However, this qualitative approach was an effective tool for developing a conceptual framework for understanding the contextually grounded and complex issues of institutional racism, which is the strength of qualitative research (Banyard & Miller, 1998; Creswell, 1998).

Future research in this area should focus on qualitative, quantitative, and action tests of the framework. Also, it will be important to develop a more rich understanding of how racism is made manifest at each level of an organization. At the extraorganizational level, because organizations are so intimately integrated with their institutional and community contexts, it is important to assess the reciprocal relationship between the two. Understanding how organizations can be oppressed, shaped, and constrained by their evolving social contexts will be a critical aspect of determining how and where to intervene to affect the most change. Conversely, examining the impact organizations have on communities, in their roles as gatekeepers to resources and opportunities, is critical to understanding how racism impacts health, well-being, and health outcomes.

At the intraorganizational level, it is critical to understand the role of racism on organizational culture, organizational climate, the material resource environment, and the institutional environment. One particularly critical and fertile ground for future study is exploring how power is distributed in organizations, and what impact that has on organizational culture, staff, and clients. Although this paper focuses on racism, because racism is rooted in the unequal distribution of power, sexism, heterosexism, or any other "ism" could fit this general framework. People are oppressed and have power on multiple dimensions and based on different aspects of their identities. Although all social identities are not viewed equally in every context, the interaction of different social groups is rooted in power. Formal and informal power differences are critical factors in administrative evil. Perspective, sunk costs, and perceptual magnitude gaps often are strongly related to social power in an organization, which includes formal and informal power. Given the work by Dreachslin and colleagues (2004), who found a relationship between access to power and job performance, and that People of Color were over-represented in positions of lower formal power, it would be critical to explore how power, formal and informal networks, and identity impact organizations. Further, understanding the impact of increasing the number of People of Color in positions of more formal power and leadership positions will be critical as we develop more evidence-based strategies to addressing health care disparities and competent and unbiased care (Dreachslin et al., 2004).

At the individual level, it is important to see how the extra- and intraorganizational factors impact how staff members complete their job tasks and interact with one another. Just as organizations occur in a social context, staff members function within that same structure. They have to decide whether to adapt (i.e., having the critical capacity to understand and make choices to transform a given context) or adjust (i.e., passively be manipulated by external forces) to that environment (Freire, 1973; Watts et al., 1999). It is this ability to see the impact of the sociopolitical environment and devise strategies to promote liberation that is the essence of what Watts calls sociopolitical development (Watts et al., 1999; Watts, Williams, & Jagers, 2003). In this context, cultural competence could be transformed into social competence, recognizing that it is important to recognize the sociopolitical context as well as unique cultural practices.

Organizational studies and community psychology have yet to adequately recognize the unequal foundation on which organizations and the fields exist, and, therefore, ". . . need more macro approaches in the organizational studies within community psychology" (Boyd & Angelique, 2002, p. 338). Consequently, unless organizations invest the time and resources to not only develop new programs, policies, and procedures, but also systematically undo and consciously address how institutional racism is made manifest in their organization, they will continue to reinforce the outcomes they are trying to change. Until racism and other forms of oppression are integrated into our understanding of organizational development and organizational behavior, we will be unsuccessful in achieving true democracy and equality, or community psychology's goal of social change.

REFERENCES

Adams, G.B., & Balfour, D.L. (2004). Unmasking administrative evil (rev. ed.). Armonk, NY: M.E. Sharpe.

Arendt, H. (1963). Eichmann in Jerusalem: A report on the banality of evil. New York: Viking Press.

Aspen Institute. (2004). Structural racism and youth development: Issues, challenges, and implications. New York: The Aspen Institute.

Banyard, V.L., & Miller, K.E. (1998). The powerful potential of qualitative research for community psychology. American Journal of Community Psychology, 26(4), 485–506.

Barndt, J. (1991). Dismantling racism: The continuing challenge to White America. Minneapolis, MN: Augsburg Fortress.

Bartky, S.L. (1990). Femininity and domination: Studies in the phenomenology of oppression. New York: Routledge.

Better, S. (2002). Institutional racism: A primer on theory and strategies for social change. Chicago: Burnham.

Bowditch, J.L., & Buono, A.F. (2001). A primer on organizational behavior (5th ed.). New York: Wiley.

Boyd, N.M., & Angelique, H. (2002). Rekindling the discourse: Organizational studies in community psychology. Journal of Community Psychology, 30, 325–348.

Byrd, W.M., & Clayton, L.A. (2000). An American health dilemma. New York: Routledge.

Chesler, M., & Delgado, H. (1987). Race relations training and organizational change. In J.W. Shaw, P.G. Nordlie, & R.M. Shapiro (Eds.), Strategies for improving race relations: The Anglo-American experience (pp. 182–204). Manchester, UK: Manchester University Press.

Contrada, R.J., & Ashmore, R.D. (1999). Self, social identity, and physical health: Interdisciplinary explorations. New York: Oxford University Press.

Contrada, R.J., Ashmore, R.D., Gary, M.L., Coups, E., Egeth, J.D., Sewell, A., et al. (2000). Ethnicity-related sources of stress and their effects on well-being. Current Directions in Psychological Science, 9(4), 136–139.

Creswell, J. (1998). Qualitative inquiry and research design. Thousand Oaks, CA: Sage.

Cuadros, P. (2000). When David Duke goes marching in. Salon.com. Retrieved February 21, 2006, from http://archive.salon.com/news/feature/2000/04/04/latinos/index2.html

Dooley, K.J. (1997). A complex adaptive systems model of organizational change. Nonlinear Dynamics, Psychology, and Life Sciences, 1(1), 69–97.

Dreachslin, J.L., Weech-Maldonado, R., & Dansky, K.H. (2004). Racial and ethnic diversity and organizational behavior: A focused research agenda for health services management. Social Science and Medicine, 59, 961–971.

Feagin, J.R. (2000). Racist America: Roots, current realities, and future reparations. New York: Routledge.

Feagin, J.R., & McKinney, K.D. (2003). The many costs of racism. Lanham, MD: Rowman & Littlefield.

Feagin, J.R., Vera, H., & Batur, P. (2001). White racism: The basics (2nd ed.). New York: Routledge.

Foster-Fishman, P.G., Salem, D.A., Chibnall, S., Legler, R., & Yapchai, C. (1998). Empirical support for the critical assumptions of empowerment theory. American Journal of Community Psychology, 26, 507–536.

Freire, P. (1973). Education for critical consciousness (1st American ed.). New York: Seabury Press.

Gabriel, B. (2002, June). Confronting "unequal treatment": The Institute of Medicine weighs in on health care disparities. Association of American Medical Colleges Reporter. Retrieved February 21, 2006, from http://www.aamc.org/newsroom/reporter/june02/unequaltreatment.htm

Gaventa, J. (1980). Power and powerlessness: Quiescence and rebellion in an Appalachian Valley. Oxford: Clarendon Press.

Geiger, H.J. (2003). Racial and ethnic disparities in diagnosis and treatment: A review of the evidence and consideration of causes. In B.D. Smedley, A.Y. Stith, & A.R. Nelson (Eds.), Unequal treatment: Confronting racial and ethnic disparities in health care (pp. 417–454). Washington, DC: The National Academies Press.

Institute of Medicine (U.S.). (2003). Unequal treatment: Confronting racial and ethnic disparities in healthcare. Washington, DC: The National Academies Press.

James, S.A. (2003). Confronting the moral economy of U.S. racial/ethnic health disparities. American Journal of Public Health, 93(2), 189.

Jones, C.P. (2000). Levels of racism: A theoretic framework and a gardener's tale. American Journal of Public Health, 90(8), 1212–1215.

Marable, M. (2002). The great wells of democracy: The meaning of race in American life. New York: Basic Civitas Books.

Maton, K.I., & Salem, D.A. (1995). Organizational characteristics of empowering community settings: A multiple case study approach. American Journal of Community Psychology, 23(5), 631–656.

McMahon, S.D., & Watts, R.J. (2002). Ethnic identity in urban African American youth: Exploring links with self-worth, aggression, and other psychosocial variables. Journal of Community Psychology, 30(4), 411–431.

Morgan, G. (1997). Images of organization (2nd ed.). Thousand Oaks, CA: Sage Publications.

North Carolina State Center for Health Statistics. (2001). 1999–2001 race-sex-specific age-adjusted rates by county. Retrieved February 21, 2006, from http://www.schs.state.nc.us/SCHS/data/databook

Perreault, S., & Bourhis, R.Y. (1999). Ethnocentrism, social identification, and discrimination. Personality and Social Psychology Bulletin, 25(1), 92–103.

Peterson, N.A., & Zimmerman, M.A. (2004). Beyond the individual: Toward a nomological network of organizational empowerment. American Journal of Community Psychology, 34(1/2), 129–145.

Pettigrew, T.F. (2004). Justice deferred: A half-century after Brown v. Board of Education. American Psychologist, 59(6), 521–529.

Polednak, A.P. (1997). Segregation, poverty, and mortality in urban African Americans. New York: Oxford University Press.

Prilleltensky, I., & Gonick, L. (1996). Polities change, oppression remains: On the psychology and politics of oppression. Political Psychology, 17, 127–147.

Rodriguez, A.M. (1987). Institutional racism in the organizational setting: An action-research approach. In J.W. Shaw, P.G. Nordlie, & R.M. Shapiro (Eds.), Strategies for improving race relations: The Anglo-American experience (pp. 128–148). Manchester, UK: Manchester University Press.

Scott, W.R., Ruef, M., Mendel, P.J., & Caronna, C.A. (2000). Institutional change and healthcare organizations: From professional dominance to managed care. Chicago: University of Chicago Press.

Smedley, B.D., Stith, A.Y., & Nelson, A.R. (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press.

Southern County Public Health Department Director. (2003). Southern County Public Health Department: July 1997–June 2002, State of the Department Organizational Self-Assessment. Southern State: Southern County Public Health Department.

Steinhorn, L., & Diggs-Brown, B. (1999). By the color of our skin: The illusion of integration and the reality of race. New York: Dutton.

Trubek, L.G., & Das, M. (2003). Achieving equality: Healthcare governance in transition. American Journal of Law and Medicine, 29(2–3), 395–421.

U.S. Census Bureau. (2000). Census 2000 summary file 1 (SF 1) matrices P3, P4, PCT4, PCT5, PCT8, and PCT11. Retrieved February 22, 2006, from http://factfinder.census.gov/ [generated by Derek Griffith using American Factfinder].

van Ryn, M., & Fu, S.S. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? America Journal of Public Health, 93(2), 248–255.

Watts, R.J., & Carter, R.T. (1991). Psychological aspects of racism in organizations. Group and Organizational Studies, 16(3), 328–344.

Watts, R.J., Griffith, D.M., & Abdul-Adil, J. (1999). Sociopolitical development as an antidote for oppression. American Journal of Community Psychology, 27(2), 255–271.

Watts, R.J., Williams, N.C., & Jagers, R J. (2003). Sociopolitical development. American Journal of Community Psychology, 31(1–2), 185–194.

Williams, D.R., & Rucker, T.D. (2000). Understanding and addressing racial disparities in health care. Health Care Financing Review, 21(4), 75–90.

Zimmerman, M.A. (2000). Empowerment theory: Psychological, organizational, and community levels of analysis. In J. Rappaport & E. Seidman (Eds.), Handbook of Community Psychology (pp. 43–63). New York: Plenum Press.

APPENDIX A. DESCRIPTION OF DATA SETS

Employee survey: An anonymous, self-administered survey of 63 items (3 demographic, 60 Likert scale) was distributed to all 85 staff members in January 2001, along with a self-addressed envelope, for mailing their completed questionnaires. The questionnaire covered the following topics: job satisfaction, organizational racial climate, and the perceived cultural competence of oneself, other staff, and the organization.

Focus group interview: Three focus group interviews were conducted with health department staff in May 2001 by **Change***work* consultants. Department supervisors selected staff to participate. Staff from management, preventive services, and health education and family services participated in separate focus groups. The issues discussed were: job satisfaction and stressors, facilitators and barriers to quality of service provision, organizational racial climate, and communication.

Community survey: In May 2001, staff members distributed a 33-item self-administered questionnaire on perceptions of the health department, and the perceived quality of their staff and services to 227 clients attending a health clinic, community events, or home visits. For Latino clients, a questionnaire in the Spanish language was offered.

Review of policies and procedures: In 2001, a racially diverse group of health department staff volunteered to review the policies and procedures of SCPHD to determine if these organizational factors were adversely affecting staff and clients. In 2003, this review was repeated by the change team to determine which health department structures, policies, and procedures helped or hindered progress toward becoming an antiracist organization, and to develop an action plan to eliminate institutional racism in the organization.

Organizational self-assessment—demographics and service delivery: In 2002, the Health Department director completed a global assessment of SCPHD to understand the state of the department. She examined data from the previous five years (July 1997–June 2002), and included information on the goals of the agency, the budget, division reports, and organizational challenges, highlighting the personnel and client demographic changes over time. The findings were presented to the Board of Health in January 2003 and the staff in February 2003.

Perceived racism questionnaire: In 2003, the change team designed a questionnaire to complement and supplement the existing evaluation measures and assess perceptions of racism at each of three levels—extraorganizational, intraorganizational, and individual. The questionnaire included 53 items and took an average of 15 minutes to complete when it was administered to 68 staff members (82% of staff) in October 2003. It included 5 demographic questions; 29 four-point, Likert-type items on perceived racism; and 18 four-point, Likert-type items that examined knowledge of different types of racism and white privilege, based on information taught by **Change***work*. There was 1 open-ended question asking for additional comments.