Caring and Carrying the Cost: Bicultural Latina Nurses' Challenges and Strategies for Working with Coethnic Patients

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In an emergent type of labor market niche, bicultural immigrants serve as cultural brokers between clients and workers and among different groups of workers whose communications are hindered by cultural and language barriers. We focus on the bicultural Latino nurses who are recruited as cultural brokers to facilitate "culturally competent care" in a predominantly white institution that serves an increasingly diverse patient population, with Hispanics being the majority-minority group. Through a qualitative study based on twenty-six in-depth interviews in Northern California, we find that these nurses adopt "code hybridization" strategies to manage their roles as cultural brokers. We discuss the larger institutional contexts that shape the successes and impacts of these strategies, as well as the theoretical implications for assimilation theories.

Keywords: nurses, Latino immigrants, cultural brokers, health care, immigrant assimilation

Scholars have richly depicted the span of immigrant labor market niches in the United States from one end of the spectrum to the other—from the most labor-intensive sectors to the very high-skilled sectors (for a comprehensive review, see Eckstein and Peri, this issue). Building upon and advancing these insights, this article, along with some new studies (for example, Da Cruz, this issue; Wilson, this issue), identifies and explores an emergent type of niche that is filled by bicultural immigrants (including second and later generations) who serve as cultural brokers between clients and workers and among workers whose communications are hindered by cultural and language barriers. These immigrant workers' unique skill set supposedly lies in their bilingualism and their alleged familiarity with both cultures.

This study focuses on bicultural Latino nurses, including licensed practical nurses (LPNs), registered nurses (RNs), and nurse-practitioners (NPs). As one of the most rapidly expanding sectors of the economy, health care

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has long been known to rely on immigrant workers to address its labor force shortages—for example, foreign-trained nurses from the Philippines (Ortiga, this issue) and Indian doctors who fill the jobs that native doctors avoid (Eckstein and Peri, this issue). The hiring of bicultural Latino nurses, however, is a response to a different demand. Instead of being asked to fill the overall RN shortage or to take undesirable jobs shunned by native workers, these nurses are being recruited as cultural brokers to facilitate "culturally competent care" in a predominantly white institution that serves an increasingly diverse patient population, with Hispanics having become the majority-minority group (Bosch, Doshier, and Gess-Newsome 2012; Institute of Medicine 2001; Thacker 2005). Put differently, we can view bicultural Spanish-speaking nursing as a niche formed by the long-term flows over the last few decades of Mexican and Central American immigrants who have flocked to the United States for low-income, labor-intensive jobs and who have become clients for health care services.

The need for bicultural Latino nurses has been extensively documented (for a literature review, see Bosch, Doshier, and Gess-Newsome 2012), and so has the shortage of these health care professionals. Citing the U.S. Census Bureau, the National Association of Hispanic Nurses (NAHN) reports that the Hispanic population reached 53 million in 2012, representing a 50 percent increase since 2000. The NAHN also reports that 41 percent of adult Hispanics did not speak English proficiently, yet Hispanics made up only 4.8 percent of RNs and 7.5 percent of LPNs (U.S. Census Bureau 2007). Indeed, the underrepresentation of minority health care professionals was recognized as an important health care concern in *Healthy People 2010,* a U.S. Department of Health and Human Services (2000) report that set the goal of awarding 12 percent of nursing degrees to underrepresented racial and ethnic groups by 2010. Current efforts to address the shortage of bicultural Latino nurses include: Spanish-English bilingual nursing programs at community and four-year colleges; state-funded scholarships for Hispanic nursing students; Spanish-competency training programs (sponsored by NAHN); and certification by the National Board of Certification for Medical Interpreters (CMI), among other initiatives. In short, the rise of the bicultural Latino nursing niche is a response to the rapid increase in the Hispanic immigrant patient population, and it is now recognized by policymakers, health care professionals, and educators as an important yet underaddressed area of expertise in health care.

Situated against this background, our research focuses on the question: How do bicultural Latino nurses address the tensions and challenges of "cultural brokerage"?[1] Although we join other scholars in highlighting the shortage of bicultural nurses and underscoring the importance of their recruitment, our purpose here is to problematize the assumption that knowing both cultures is tantamount to being able to successfully engage in cultural brokerage. More specifically, we situate bicultural Latino nurses in a workplace context—a white, mainstream institution—in which they are expected to adhere to professional norms and organizational regulations while simultaneously addressing their coethnic patients' cultural understandings, practices, and other life-context concerns, with the former expectation routinely regarded by most colleagues as more important than the latter. How do they work in this context as cultural brokers? How do these immigrant health care professionals, straddling both worlds, manage to develop a coherent workplace identity, if any at all? How does the larger organizational environment shape their strategies and challenges?

Drawing on twenty-six in-depth interviews in Northern California, our research addresses

1. Originally developed by the anthropologists Eric Wolf and Clifford Geertz, the notion of "cultural brokerage" has generally been defined as bridging, linking, or mediating between groups or persons from different cultures. Scholars have applied this notion to the context of clinical interactions, especially for studying the roles of nurses and medical interpreters. Informed by Lo's earlier work on patient culture, we further specify cultural brokerage as the mutual inclusion of seemingly incongruent sets of schemas or cultural orientations (Lo 2010).

these questions in a qualitative study. As detailed in the findings section, we find that nurses' practice of cultural brokerage is hardly uniform and instead involves diverse strategies of what we term "code hybridization"—namely, blending different parts of two cultures to avoid (or to confront) certain social tensions and power hierarchies.

THEORETICAL FRAMEWORK AND CONTRIBUTIONS

To address our questions about bicultural Latino nurses' cultural brokerage strategies and workplace identities, we borrow theoretical insights from two bodies of sociological literature: studies of ethnic concordance and cultural competency, and research on immigrant and minority middle-class identities. The former helps us conceptualize the tensions of cultural brokerage; the latter offers a frame for discussing cultural brokers' strategies. More broadly, our research has important theoretical implications for assimilation theories in that it highlights the function of bicultural immigrants' "biculturality"—rather than assimilation or ethnic retention—as a special job skill in today's American labor market.

Does Ethnic Concordance Promote Cultural Competency?

In almost all sociological literature, it is assumed that assimilated Latino immigrants (including second and later generations) are the natural candidates for bridging the two cultures. This assumption resonates with the larger policy discourse on "ethnic concordance" within health care—the matching of the ethnicity of patients and health care workers. In these policy discussions, increasing the ethnic concordance between patients and health care workers is promoted as a measure to deliver "culturally competent health care" and thereby improve the quality of clinical interactions for minority patients in the United States (Brown et al. 2007; Cooper et al. 2003; Institute of Medicine 2001). Proponents of ethnic concordance argue that coethnics are likely to share similar cultural beliefs and social experiences and thus will develop mutual respect and trust (Cooper et al. 2003; LaVeist and Nuru-Jeter 2002), communicate better, and achieve greater partnership in the patient's health care (Meghani et al. 2009).

This assumption is challenged by an ambiguous empirical picture. On the one hand, research does document that some patients report a preference for an ethnically concordant provider (Garcia et al. 2003) or that they evaluate concordant health care encounters as more satisfying and communicative (Cooper et al. 2003; LaVeist and Nuru-Jeter 2002; LaVeist, Nuru-Jeter, and Jones 2003). Some studies show that patients receive better care and are more likely to use care services when in an ethnically concordant relationship with their provider (King et al. 2004; Modi, Whetstone, and Cummings 2007).

However, just as many studies report the opposite finding. Several studies find that concordance is not correlated with patients' ratings of care, clinical experiences, or health outcomes (Clark, Sleath, and Rubin 2004; McKinlay et al. 2002; Saha, Arbelaez, and Cooper 2003; Stevens, Shi, and Cooper 2003). Janice Blanchard, Shakti Nayar, and Nicole Lurie (2007) report that, for Latinos, concordance has negative effects—patients are more likely to rate clinical encounters with coethnic providers as disrespectful. Other studies show that the effects of ethnic concordance vary widely across racial groups (Blanchard, Nayar, and Lurie 2007; Garcia et al. 2003). Even within the same ethnic group, ethnic concordance assumes different levels of significance in the varying life contexts of patients (Bender 2007; Garcia et al. 2003; Malat and Hamilton 2006).

More fundamentally, many sociologists challenge the core premise of ethnic concordance policies for its simplistic view of patient culture. Concordance policies rest on the assumption that coethnics share crucial values and cultural practices, and that this common set of values and practices, in turn, facilitates clinical interactions. Explicitly or implicitly, this assumption has been questioned by countless studies, which reveal that patient culture is shaped not only by ethnicity but also by gender, class, educational background, immigration status, and other social forces manifested in the patient's life context (for a comprehensive review, see Lo and Stacey 2008). Rather than equating patients' culture with their eth-

nicity, these studies suggest that patients' culture should be understood more broadly and flexibly as the patients' sense-making schema shaped by diverse social forces (ibid.). Patients resort to such schemas or frameworks for understanding clinical procedures and interactions and situating their medical decisions amid competing priorities in their lives.

Viewing culture as intersectional, these researchers argue that the key to accommodating patient "culture" in the clinic lies not in matching the ethnicity of patients and health care workers, but in prompting health care workers to allow and help patients to situate their health and health care in relevant life contexts. In an influential framework for these discussions, a patient's life context is conceptualized as the patient's "lifeworld," which can be briefly defined as the patient's contextually grounded experiences of events and problems in everyday life whose significance depends on the patient's biographical situation and position (for reviews of the literature on patient lifeworld, see Barry et al. 2001; Lo and Bahar 2013). It is argued that the quality of care is compromised when, in clinical interactions, the "voice of medicine" (which is dominated by doctors' biomedical framework and oriented toward the goal of patient compliance) overpowers or marginalizes the "voice of lifeworld" (which is inclusive of patients' preferences and experiences and oriented toward doctor-patient consensus through negotiation) (Barry et al. 2001; Greenhalgh, Robb, and Scambler 2006; Leanza, Boivin, and Rosenberg 2010; Mishler 1984; Porter 1998; Stevenson and Scambler 2005). Health care professionals, in general, are reported to be inclined to disengage from the patient's lifeworld, but they are found to be particularly likely to do so with minority or immigrant patients, whose lifeworlds are socially and culturally more marginalized (Lo 2010; Lo and Bahar 2013).

As Sarah Willen and Elizabeth Carpenter-Song (2013) put it, scholars and practitioners have now reached the point where it will be fruitful to move beyond rearticulating these well-published critiques of ethnic concordance and cultural competency policies. To the extent that "patient culture" still functions as a placeholder for talking about many dimensions of social experiences in the clinic (in other words, the patient lifeworld), it should not be treated merely as a conceptual category to be criticized and retheorized (Good et al. 2011). Instead, analyzing the ways in which health care workers discuss and address "patient culture"—however imperfectly or simplistically they may define it—provides us with an important window to understanding the on-the-ground challenges and creativity of health care workers who have begun to wrestle with these messy lifeworld issues. For example, immigrant health care professionals are still commonly expected to perform the role of cultural brokers at hospitals and clinics, despite the aforementioned research challenging the very rationale of this expectation. Yet we have little understanding of how these health care workers manage being assigned the task of bridging the norms of the clinic and the lifeworlds of coethnic patients. Documenting and theorizing their challenges and coping strategies will help us better understand the complexity of cultural brokerage in health care.

The Identities of Immigrant Professionals: Code-Switching or Code-Hybridizing?

We take up this task by focusing on the experiences of Latina nurses who regularly care for Latino patients. We incorporate insights from the literature on immigrant and minority middle-class identities to help frame the patterns emerging from our interview data. More specifically, this literature sensitizes us to the interclass boundaries (with coethnics) and interethnic tensions (with white colleagues) that middle-class minorities and immigrant professionals are challenged to negotiate. Our interviewees reported similar (but not identical) patterns of boundary-crossing in their experiences. Meanwhile, studies on Latino and other middle-class minorities generally identify "code-switching" as their main coping strategy—for example, signaling white middle-class cultural cues at work and in public and engaging in ethnic cultural practices when visiting coethnics (Agius Vallejo 2012; Agius Vallejo and Lee 2009, Neckerman, Carter, and Lee 1999). Furthermore, some of these middle-class minorities may establish ethnic professional organizations that enable them to collectively

process the stress of straddling two social worlds and reflect on the meanings of their identities as middle-class blacks, Latino teachers, and the like. Similar to what Nancy Fraser (1995) describes as counterhegemonic publics, these ethnic professional associations provide a "training ground" for upwardly mobile minorities to experiment with ways of hybridizing multiple cultural codes. But in coethnic clinical interactions, multiple sets of tension are compressed into the singular social space of the clinic, accentuating both ethnic and professional identities in a mainstream institution, which in turn renders unusable the common coping strategies of code-switching and counterhegemonic publics. Indeed, our interviewees were expected to provide "culturally sensitive" care to coethnic patients and *simultaneously* adhere to clinical regulations and norms and conduct themselves professionally in front of patients, doctors, and other hospital staff. We investigate how these Latina nurses developed new coping strategies—which we term "code hybridization"—in this context.

How Does "Biculturality" Function as a Job Skill for Immigrants?

Our case study of bicultural Latina nurses has broad theoretical implications beyond the discussions of cultural brokers in health care settings and their workplace identity strategies. For immigration scholars in general, the workplace experiences of our Latina nurses, who were both first- and later-generation immigrants, broaden the framework of the segmented assimilation theory (Portes and Zhou 1993). Extending segmented assimilation theory's argument that immigrants' "biculturality" can function as an advantage for school-age youths, our study is among the first to show how biculturality can also function as a job skill for immigrant adults. Meanwhile, we caution that cultural blending as a job skill can be put to use most effectively—benefiting not only bicultural immigrant professionals themselves but mainstream American society—only when appropriate institutional support is in place. Furthermore, we qualify segmented assimilation theory's assumption that, for immigrant youths straddling two cultures, cultural blending occurs more or less automatically. Indeed, our findings will concretely illustrate how immigrant and American cultures are blended on the ground.

The segmented assimilation theory has been extremely influential in demonstrating the benefits of biculturalism for immigrant youths. Scholars observe that bicultural immigrant youths learn English and participate in American cultural activities at school, while embracing their parents' languages and cultural practices at home. The sharing of languages and cultures in the home space, in turn, allows parents to offer guidance and support, protecting these youths from the oppositional cultures in inner cities. Statistically, the second-generation immigrants who follow this path—termed "selective acculturation" in this literature—appear to perform better in school and garner better economic prospects than those who opt for either complete assimilation or oppositional ethnic pride (Kasinitz et al. 2008; Portes and Rumbaut 2001). However, as Mary Waters and her associates (2010) have argued, these insights about immigrants' bicultural advantage rest almost exclusively on the empirical evidence about school-age children. To date, little is known about whether, and how, bicultural second-generation immigrants translate their bicultural advantage from educational settings to the job market. Our study is one of the first to illustrate how immigrant professionals (including, in our case, first-, second-, and later-generation immigrants) can enjoy a special market niche thanks to their cultural blending skills.

Furthermore, while cultural hybridization lies at the core of the selective acculturation model, the concrete processes of hybridization tend to be assumed rather than analyzed in this literature. To be sure, scholars have documented the mechanisms that can encourage the preservation of home cultures for immigrant youths—such as ethnic networks or civic organizations in their ethnic enclave. But little is said about how these youths actually *blend* their ethnic culture with American ways, or how they resolve the tensions that arise from such cultural blending. Being immersed in two cultures is often assumed as tantamount to naturally knowing how to mix them. Substantiating as well as qualifying such assumptions,

our findings illustrate *how* Latina nurses can deploy ethnic identities at work, and integrate them with their professional identity, when they have access to particular resources and cultural flexibility in their workplace settings. In the absence of such institutional support, as our findings indicate, their ethnic identities can pose challenges to bicultural nurses' professional status or identities. We elaborate these theoretical insights in the conclusion.

METHOD AND DATA

Design and Setting

We use in-depth interviews and grounded theory methodology to understand bicultural Latina nurses' experiences with Latino patients in health care contexts in Northern California. Northern California is one of the most diverse regions in the United States, with a long history of receiving immigrants from Asia and Latin America. While nationwide Hispanic Americans are the largest minority group (16 percent according to the 2010 census), California is the state with the largest Hispanic population. In Northern California, almost one-quarter of the residents are Hispanic.

The Hispanic residents of Northern California generally mirror their national counterparts in terms of education and poverty levels. As shown in appendix figure A1, compared to the national average, Hispanics are both more likely to have less than a high school education and less likely to be college-educated. Compared with other racial groups, Hispanics lag behind Asians, non-Hispanic whites, and African Americans. The trends in Northern California are similar.

Nationally, Hispanics (along with African Americans) are also more likely to live in poverty (see appendix figure A2). Similar patterns are found in Northern California. Appendix figure A2 shows the average proportion of individuals from each group who are Medicaid-eligible—that is, those whose individual incomes are 133 percent of the federal poverty level or less. In Northern California, almost 30 percent of Hispanics are Medicaid-eligible, compared to fewer than 20 percent of non-Hispanic whites and Asians.

To meet the health care demands of the large and socioeconomically disadvantaged Hispanic group, many policy prescriptions center on increasing the numbers of Hispanic health care professionals as cultural brokers, as discussed earlier. But as also noted, there has been a significant lag in the actual implementation of these policies (Sánchez et al. 2015). This national trend is largely mirrored in Northern California. In 2012–2013, Hispanics made up 6 percent of the physician workforce nationwide, and a little over 4 percent in Northern California. Hispanics are also underrepresented among registered nurses (4.7 percent nationwide, 6.4 percent in Northern California) and nurse-practitioners (4.1 percent nationwide, 11.1 percent in Northern California) (see appendix figure A3). In focusing here on Latina nurses, we set aside the experiences of Latino physicians for future research, given that the two groups differ greatly in professional status, workplace identity, and relationships with patients.

Recruitment

Most, if not all, ethnic concordance policies assume that immigrants (including second and later generations) are the natural candidates to fill the bicultural nursing niche. But as we discussed earlier, an intersectional understanding of culture has led most sociologists to debunk the overly simplistic equating of ethnicity with culture. Empirically, bicultural nurses familiar with Latino cultures are mostly, *but not exclusively,* Latino immigrants (both foreign-born and later-generation). Acknowledging this observation, our study includes a small number of white Spanish-bilingual nurses; their experiences accentuate the unique identity challenges faced by our main group of interviewees, bicultural Latina nurses.

Those meeting our criteria for recruitment were Spanish-bilingual nurses who had worked with Latino patients in a health care setting for at least six months. After receiving ethics approval from the institutional review board at the University of California–Davis, we recruited nurses by posting information about the project in medical facilities and on social media sites relevant to Latino nursing groups. Snow-

Table 1. Demographic Characteristics of Spanish Bilingual Nurses in the Sample

Race	
Hispanic	80.8%
White	15.4
Biracial (Hispanic-white)	3.8
Ethnicity	
Colombian	3.8
Costa Rican	3.8
El Salvadoran	15.4
Guatemalan	11.5
Mexican	34.6
Nicaraguan	3.8
Peruvian	3.8
Multiethnic Latino	3.8
White	15.4
Biracial	3.8
Immigrant generation	
First generation	7.7
1.5 generation	34.6
Second generation	42.3
Third or later generation	15.4
Workplace	
Community clinic	23.1
Hospital	38.5
Public health	30.8
Other	7.7

Source: Authors' calculations of Bicultural Nurses' Study data.

ball sampling was also utilized to recruit nurses.

The Sample

Table 1 offers a summary of the demographic characteristics of the nurses in our sample: twenty-two Hispanics and four fluently bilingual, non-Hispanic whites. In a female-dominated profession, male nurses (n = 1) were less available than female nurses (n = 25) to be interviewed. About 60 percent of our interviewees were U.S.-born (second- and third-generation immigrants); 40 percent were foreign-born. They worked in community clinics, hospitals, and county public health services, where they provided primary, acute, and specialty care.

Data Sources

Data were collected between July 2012 and October 2013 through in-person, in-depth, audio-recorded interviews with each nurse. The interviews were conducted in English by the authors or research assistant and lasted roughly one to two hours. We provided a summary of the research project and obtained written informed consent at the start of each interview. A flexible interview schedule guided participants through a conversation on three broad topics. The first set of questions pertained to the interviewee's educational and professional trajectory and previous and current workplace settings. The second set of questions asked the nurses to discuss their interactions with Latino patients and reflect upon what they viewed as the key challenges, rewards, and professional goals in serving co-ethnic patients. We encouraged them to describe these experiences and reflections in their workplace contexts, including organizational resources, regulations, cultural norms, and interactions with other patients, fellow nurses, providers, or other hospital personnel. Finally, we invited them to reflect on their ethnic identity and describe their relationship to their ethnic community. Throughout the interview, nurses were encouraged to offer specific examples.

Data Analysis

Interviews were transcribed by trained research assistants and analyzed with a grounded theory approach. We first read interview transcripts in their entirety to gain a holistic understanding of the nurses' experiences. Using themes that emerged from these readings, we generated broad codes. We then refined and reapplied critical codes to the data, which allowed us to inductively identify analytical patterns. Also, we observed relationships between these analytical patterns, both within and across interviews. This coding process was inductive and recursive, totaling three rounds of double-coding by both authors. In each round, each author coded all transcripts independently, and any discrepancies between coders were resolved through discussions and clarifications of the meanings of specific codes. To

preserve confidentiality, we used pseudonyms to refer to all people and places in the nurses' accounts.

FINDINGS

Expected to provide "culturally sensitive" care to coethnic patients while simultaneously operating within clinical regulations and professional norms, the Latina nurses in our study engaged in practices that we describe as code hybridization. Most of them embraced the key professional norms, such as the scientific superiority of biomedicine, the rationality or at least necessity of institutional procedures, and the value of professional universalism—that is, the principle that all patients were to be cared for equally well regardless of racial or ethnic bonds, social status, and other nonprofessional identity markers. At the same time, many (though not all) of them endorsed a countercurrent within the medical institution: an emphasis on the importance of patient lifeworld—namely patients' experiences of everyday events and problems whose meanings are shaped by the patient's larger life context (Barry et al. 2001). Latina nurses found their voices in the counterhegemonic professional ideal of lifeworld communications, through which they articulated how their shared ethnic heritage improved and enriched their clinical interactions with coethnic patients. Furthermore, some nurses developed a vision of what we term "relational communities within the clinic," which featured shared emotional bonds and vulnerable moments between caregivers and care-receivers. For these nurses, relational communities with coethnic patients were not merely instrumental in providing better biomedical care; they were valuable in themselves for empowering both nurses and their coethnic patients in a white-dominant institution. More broadly, they viewed relational communities as a means to restoring culture and humanity to the practice of health care. In mixing biomedical norms with ethnic bonds and cultural perspectives, Latina nurses resorted to, and at times broadened, counterhegemonic professional discourses in U.S. health care institutions.

However, significant and often unresolved tensions accompanied nurses' practices of cultural blending. Many found that professional universalism and relational communities were difficult principles to reconcile; the institutional norms of efficiency often pushed against the space for lifeworld communications, and the desire to form ethnic bonds and the quest for professional status were at times in competition. These tensions could impose costs and present challenges to the nurses' careers.

How, and how well, our interviewees managed these tensions and challenges differed according to their specific mode of code hybridization. At the same time, code hybridization patterns suggest different emergent workplace identities among Latina nurses. Specifically, our findings suggest four patterns of code hybridization and workplace identity among Latina nurses.

The Cross-Functional Professionals

Working within the biomedical framework, these nurses expressly incorporated concerns from their patients' lifeworlds; doing so, they emphasized, facilitated biomedical approaches rather than interfered with them. Their medical and ethnic representations blended together to facilitate professional interactions that were culturally meaningful to patients. We describe these nurses, who engaged in the most robust form of code hybridization, as "cross-functional professionals." However, nurses only become cross-functional professionals if they enjoy strong institutional support—for example, adequate resources, autonomy over their work schedule, and a workplace culture supporting their unconventional practices. Not surprisingly, only a few Latina nurses in our study derived their workplace identity from being able to work cross-functionally.

Cross-functional professionals articulated a nuanced and in-depth understanding of how coethnic patients' lifeworlds were imminently relevant to their health care and could not be bracketed. They illustrated this perspective with countless examples of clinical communications and medical goals being thwarted by doctors' misunderstandings about Latino patients' styles of interaction, their cultural capital deficits shaped by ethnicity, class, immigration status, and so on, and the material constraints they experienced from the compet-

ing priorities in their everyday lives. Alba, a fifty-seven-year-old Mexican American pediatric nurse-practitioner, described herself as the institution's "acculturation coordinator"; she consulted with patients who had been "yelled at by their doctors" for repeatedly disobeying their doctor's recommendations of lifestyle changes to control their diabetes, hypertension, or other chronic diseases. She explained to her patients that the doctors "are worried about you. But they don't have time to explain everything." In contrast, she did take the time to situate clinical conversations about diet changes in the context of a patient's everyday food choices:

> I understand that when they go to make food choices in the supermarket, because they don't speak the language, because they don't read or write, sometimes either in English or Spanish, they look at pictures to make . . . a healthy choice. So we have to talk a lot about when you see a picture of an apple on a juice can, that doesn't mean it's healthy. But they think it does. . . . We also talk about . . . McDonald's, the fast-food burgers, because they talk to me about affording to feed their family on the Dollar McDonald whatever. And I have to tell them that the whole reason it's affordable is because it's high-fat. Fat is affordable and fat's hurting you. . . . So I have to talk to them a lot about marketing and advertisement, of how it works here in the United States, and the kind of ingredients they use in the United States, because it's different from what they use in Mexico. And I know that because I lived in both countries.

Similarly, Suzanna, a twenty-nine-year-old public health nurse, engaged in a contextualized discussion about following a medical regimen with her coethnic patient who got into a "yelling match" with the provider:

> This provider had been with this family for several months. And since the beginning I think she could only see the patient as neglectful. . . . And I feel like a lot of interactions, the providers don't give the education or the tools or the knowledge to succeed, and work to meet the clients with where they're at. They expect perfection from the beginning. But these are people with very low education, language barriers, and cultural barriers. So, with this client, they got into a yelling match. And at some point I had to jump in and kind of ask some more questions. So I said, "Why didn't you give them [the client's children] medication on time?" She [the client] said, "Oh, it's summer. We're out and about. And seven o'clock is really early. And it's light out. So I forget what time it is, and when we realized what time it is when we get home, I think it's already too late." [Then I ask], "Well, what time do you get home?" [The client replies], "Well, I get home about 7:45 to 10:30." And so then, the doctor says, "Well, you can take the medication at 7:45, or you know, as late as 8:30, nine o'clock." So that gave the parent a little more information to be able to administer the medication correctly. So after that, she didn't miss a day of the medication because she knew she had wiggle [room].

These nurses' perspective resonates with the sociological research on lifeworld communications in the clinic (Barry et al. 2001; Greenhalgh, Robb, and Scambler 2006; Leanza, Boivin, and Rosenberg 2010; Mishler 1984; Porter 1998; Stevenson and Scambler 2005) in illustrating that the quality of care is often compromised when the "voice of lifeworld" (which is inclusive of patients' experiences and oriented toward doctor-patient consensus) becomes distorted by the "voice of medicine" (which is dominated by doctors' biomedical framework and is oriented toward the goal of patient compliance).

In addition to being able to engage in in-depth communications, cross-functional professionals address the lifeworld constraints faced by Latino patients, who are mostly low-income, by connecting them with resources both inside and outside the system. As illustrated in Reyna's account, lifeworld communication is not only about being respectful of patients' styles or perspectives but also, and equally importantly, about finding the resources they need to address their lifeworld constraints:

> A lot of them come to the city from towns . . . where they can't get the treatment they need. . . . So they bring family from these faraway places, and our policy is that only one person can stay, and I know they don't have the resources to go stay at a hotel. And that's really hard for me, and I tend not to tell them, "Only one person can stay." I usually try to accommodate at least two in the room, and the other ones, I'll say, "Okay, you can go to the waiting room, I'll bring you blankets, I'll bring you sheets." . . . Because I know they don't have the resources, and their family member just got out of surgery at like six or seven o'clock at night, and then they [would] have to drive two and a half hours [if they were to go home]. . . . The next day I communicate with the oncoming nurse, "They need social work, they need a case manager." Social work means to give them food vouchers, talk to the family and see what they might be able to afford. There's a church really close to us, and they have little dorms. So they work with them, on trying to get them a place to stay. Or I'll tell them, "I'm going to be the nurse for the next three nights. Your loved one is going to be in my hands, they're going to be fine. You can go home and get some rest and come back."

While these nurses offered an intersectional view of their coethnic patients' lifeworlds, they nonetheless emphasized that sharing a cultural background with coethnic patients gave them a unique set of cultural resources to use in addressing these patients' (intersectional) lifeworld concerns. Alba believed that her understanding of how the Mexican food market and health care system differ from their counterparts in the United States facilitated her cultural brokerage work for her Latino patients. Suzanna's Mexican background, she felt, helped inform the types of questions and concerns she addressed with her coethnic patients. These nurses did acknowledge their differences from their coethnic patients, but they used what they believed to be their shared culture as a basis for bridging these differences. Suzanna, for instance, recognized that, though she and her coethnic patients shared the Spanish language, she needed to go out of her way to learn some specific cultural colloquialisms:

> I think all Spanish-speaking people understand that there's some general type of Spanish, but then there are colloquial types of words that we use. And so I know that, when I say a certain word but you are Salvadoran and you have a different word for that, we know that there's a difference and we reconcile it pretty easily.

Maria, a fifty-two-year-old El Salvadoran nurse who worked at a women's health clinic, felt that her language abilities allowed her to provide better care and have a warm relationship with her Spanish-speaking patients, but she had to speak more simply with these patients, as well as tune in to a different cultural style of interaction:

> You can talk right, but [my coethnic patients] can't, [because of] the low education. We need to go to their level and explain the stuff more slowly and more carefully. And for them, they feel more confident when somebody speak the language. . . . It's [also] cultural; [Hispanic] people are afraid to [ask questions]. Because [providers] explain something, but [the patients] don't know clearly what they say but they are afraid to ask questions. *I am more sensitive in that point.*

Further, even though they had secured remarkably higher education and socioeconomic statuses than most of their coethnic patients, the cross-functional nurses said that their Latino patients often reminded them of their own immigrant parents and relatives. Accordingly, they expressed an emotional closeness with these patients as well as a strong motivation to help and care for them. Reyna, a Mexican American nurse who worked in surgical oncology, empathized with her coethnic patients and wanted to help empower them. This desire stemmed in part, she said, to having witnessed her own mother's struggles in the U.S. health care system:

> One of the greatest things about nursing [is] that I can get to know my patients and help

them heal and get better, and educate them. . . . "This is your body, this is your life. Don't hesitate to ask questions, 'cuz no question is dumb." You know, and a lot of people can come in that way, and *I know my mom did too,* and she was educated, and she had a daughter who was working in the health field, but she still felt she couldn't ask questions.

As illustrated by these examples, lifeworld-sensitive care requires not only an in-depth understanding of lifeworld issues and a willingness to help but also time, material resources, and the professional autonomy to flexibly adjust work schedules and adapt regulations to accommodate patients' needs. Indeed, stories featuring a cross-functional professional identity were told only by interviewees who described having significant institutional autonomy and access to relevant resources. Alba explicitly portrayed her cultural brokerage work as not only approved but greatly appreciated by her colleagues, and it was clear that institutional support gave her flexibility and latitude over her schedule and pace at work. Suzanna worked with providers who did not tell her to simply do what the doctors had ordered, but allowed her to jump in and intervene. Reyna had the institutional autonomy to bend the rules and let extra family members stay in patients' rooms, and case workers at her institution worked with her to help patient families gain access to food vouchers. These nurses also mentioned gift cards, financial support for motels, and transportation assistance (for example, sending a community volunteer driver to pick up a patient) as concrete measures taken at their institution to help patients obtain the treatment they needed.

In short, the cross-functional professionals can be described as "code hybridizing" in that they expand professional boundaries to accommodate ethnic bonds, an approach that is accepted at their institutions as an effective way to provide high-quality and lifeworld-sensitive care. Such an organizational environment seems to prevail, however, in only a few small pockets within U.S. health care. Among the Latina nurses in our study, the cross-functional professionals were unique in being able to achieve a coherent workplace identity that validated both their professional and ethnic identities.

The Reformers Within

The nurses who were "reformers within" had similar goals for addressing patient lifeworlds as their "cross-functional" counterparts, but had fewer resources, less institutional autonomy, and sometimes deeper conflicts between their workplace duties and visions of lifeworld-sensitive care. Lacking adequate institutional support, yet unwilling to compromise their professional visions, these nurses felt that they were going it alone with their efforts. These "reformers within" were nurses who articulated deeper criticisms of the dominant norms in their institution than other interviewees, as well as more progressive counterhegemonic visions of care. They also incurred greater professional costs.

The reformers nurses often challenge workplace norms directly—for example, by confronting doctors who are rude or culturally insensitive, giving patients permission to modify doctors' orders, making room for alternative medicine, and honoring the "wisdom" in the community—and go out of their way to help patients navigate the system and cobble together resources. Gabrielle, a triage nurse, said, "I sometimes push a little bit further with the doctor, and then I'll just call the patient directly." Yolanda, a fifty-two-year-old public health nurse whose parents were migrant farmworkers from Mexico, described similar interactions: "I remember turning my back to [a doctor] and apologizing for the doctor and saying, 'We can do it his [the doctor's] way. Or we can do it the way that you will find more comfortable or that you know you can accomplish. The goal is to make it successful for your son.'" Commenting on helping her low-income Latino patients in general, Yolanda said that "you have to go begging sometimes" in order to find resources for these patients. Both Gabrielle's and Yolanda's examples illustrate the lengths to which reformers will go to advocate on behalf of their patients, even sometimes risking their professional standing by disagreeing with physicians or taking it upon themselves to "go begging."

Often feeling alienated in their work environment, the reformers develop a counterhegemonic vision of a "relational community in the clinic" in which health care workers build rich relationships with patients that go beyond the goal of professional rapport. In these relationships, reformer nurses position themselves as both givers of care and recipients of warmth and love. These relationships allow immigrant nurses and patients alike to be, as one nurse put it, "empowering each other in the care." Isabella, a twenty-eight-year-old Guatemalan intensive care unit nurse, described caring for and cleaning a patient. She emphasized the vulnerability and trust involved in the act:

> People trust you and invite you into their little worlds [to clean their bottoms], and I actually appreciate that a human being is willing to let another human being take care of them. I think it's actually one of the most beautiful parts of our job, even though it's kind of the most demeaning part—*seen* as demeaning by other people. . . . But a lot of us, I think, fight to be the advocate for the patient. We do care.

These nurses' experiences are illustrative of Arthur Frank's (1996) "wounded healer," who, in the process of giving care, expressing compassion, and developing companionship, recovers her own humanity. Their accounts of these day-to-day interactions also place Frank's vision in concrete institutional settings. The reformer nurses reported having little institutional support; consequently, they individually bore the costs of "doing the right thing," from putting in extra work and dealing with time management difficulties to suffering the disapproval of colleagues and physical and emotional burnout. Dolores was a twenty-eight-year-old Mexican American nurse working in primary care who had previously worked in a public health clinic. She would go out of her way to assist her patients, even taking one to her appointment at Planned Parenthood on her own time. Maintaining the same sense of mission at her current position, but with less institutional support, Dolores felt as if she was doing two separate jobs: empowering culturally marginalized patients while meeting the demands of her daily routine:

> You're providing medical care, getting vital signs, giving the injection, but then you're also trying to—if you care a lot—you're trying to give the patient space to express their culture, and then having to interpret that to the provider who maybe doesn't care, maybe has their own stereotypes. . . . I haven't burnt out yet, but a lot of nurses get burnt out eventually.

Furthermore, deviating from the norm of professional detachment, nurses in the relational community allow themselves to be emotionally vulnerable to patients' deaths, losses, and judgments. Isabella described this emotional vulnerability:

> I think one of the hardest things working with transplant patients is, they're my favorite patients, but I remember when I lost my first transplant patient. . . . Her name was [also] Isabella, and she was my same age, and she had gotten a heart transplant and then four months later, she died. . . . So I think that hits you when you start establishing relationships and you're young, 'cause I was twenty-three at the time. And you see, you know, these are people, but they're also—they're ticking time bombs in a sense, their days are limited.

She elaborated:

> I'm glad that I was there. I tend to always be there when my favorite patients die, and I don't know why that ends up happening. You know, I admit them and I'm there and help them pass on. But, I like being there. Because I don't feel like I would trust anybody else to do it as good as I could do it, and be there, and the family needs me. . . . We've built this relationship, and it's just appropriate that I'm there, so I feel closure in that sense, or satisfaction in knowing that this is the best way it could be.

This is an eloquent description of how a nurse and her "favorite" patients (and their families)

grant each other support with their presence during such final moments. For Isabella, the emotional bond had grown beyond what was prescribed by her professional role—she would not "trust anybody else to do it" and she needed to be there when a patient died to "feel closure."

By the same token, and notwithstanding the ideal of professional universalism, these nurses admit that they feel greater emotional affinity with coethnic patients than any other patient group. Isabella's "relational community" with coethnic patients developed easily because they reminded her of "my loud, obnoxious Hispanic mother" and because "we Hispanics are loud, cynical people." She contrasted these relationships with her interactions with Chinese patients, whom she experienced as culturally distanced from her and therefore challenging to bond with. Such explicit celebration of ethnic solidarity in the clinic, however, can invite colleagues' questioning or disapproval. Dolores's supervisors sometimes reprimanded her for not being "a team player" with the other health care workers when she advocated for her coethnic patients, and her coworkers often asked her: "Why is race such a big deal for you?"

If the cross-functional nurses engage patient lifeworlds to ensure that they provide quality care, the reformer nurses enter the relational community as a goal in itself—to secure a space for themselves and for their coethnic patients to express their culture and humanity within an otherwise sterile and bureaucratized social world. Reformer nurses make their workplace identity coherent largely by prioritizing ethnic relationships over institutional norms—but with certain costs to their careers.

The Medical Missionaries

In contrast to the reformers, some Latina nurses fully endorse the dominant cultural and bureaucratic norms of the clinic. They embrace ethnic bonds with coethnic patients only as a means to helping them assimilate into the world of modern medicine. We describe these nurses as "medical missionaries."

Medical missionaries have a fairly black-and-white perception of biomedicine and institutional regulations, which they consider utterly superior and non-negotiable. Patient cultures and other lifeworld perspectives, in their view, are merely "excuses" for noncompliance or obstacles to assimilation. Xena, a nurse who worked in a mobile clinic, said that she did not "try to sugarcoat" what the patient said when she reported to her supervisors, nor did she offer anything "out of the scope of what we do" to patients. Beatrice put the responsibility on her patients to learn and adopt norms of clinical communication. Rather than empathizing with her coethnic patients, who tended to be fearful about offending authority figures with questions, disagreements, or explanations for their "noncompliance," Beatrice faulted them for being "deceitful." She elaborated:

> [Hispanic patients] don't want to tell you the whole story. Because they might feel embarrassed for something that they did, or didn't do. . . . I think they have more tendency to hide information. . . . I tell them, "If you want us to help you, the only way we're going to help you is if you give me all the info."

Sometimes medical missionaries get exasperated with coethnic patients whose views of medicine might appear far-fetched and misguided. Zola explained that her patients from Mexico believed that, in coming to the United States, with its advanced medical practices and technology, they would automatically be cured. She was impatient with these inaccurate perceptions: "Sir, you are paraplegic; you're not going to get any better. Do you know who Superman [actor Christopher Reeve] is? He had all the money in the world, and he didn't get better. If you're paraplegic, you're paraplegic."

Despite their hard-liner attitudes, most medical missionaries explicitly convey a sense of communal affinity with Latino patients. Like their cross-functional counterparts, they are often reminded of their immigrant parents and relatives by their coethnic patients and thus feel particularly obligated to help this patient group. Their "help," however, comes primarily in the form of top-down education rather than cultural flexibility toward interactional styles and other lifeworld practices. Julia, a specialty nurse, saw Latino patients' barriers in terms of

their deviation from the cultural norms of the clinic—for example, not educating themselves, not asking enough questions, and being too accepting of authority—and saw medical education as the solution. At the same time, she recognized these issues in her own family and felt sympathetic: "[Even] in my own family . . . what the providers say is what it is, and there's no questioning of what the provider's asking for."

Like the reformers, medical missionaries are able to resolve most tensions between their professional and ethnic identities, but they do so differently. Instead of prioritizing ethnic relationships, medical missionaries resort to institutional norms and procedures to define patient deservingness (asking, for example, "are they willing to be assimilated?") and the scope of what even a caring professional can do ("my hands are tied"). Beatrice stated that "all I can do is to give them the information, and then it's their choice." Xena noted that a nurse following professional norms may seem distant and cold to patients, but she was not apologetic about creating that impression. She defended and abided by those professional norms.

In short, the medical missionaries' workplace identity is primarily informed by professional cultures and institutional norms, and their ethnic identity gives them only an enthusiasm for assimilating coethnics into the world of modern medicine.

The Conflicted Coethnics

It is noteworthy that the workplace identity of almost half of our Latina interviewees was that of what we term the "conflicted coethnic." These nurses found it important to engage in coethnic patients' lifeworlds, yet in doing so, they reported, they encountered many institutional barriers. For instance, they were sensitive to Latino patients' styles of interaction (for example, storytelling, being overly deferential), but they needed direct information to work with; they wanted to provide meaningful support to coethnic patients and take more time to help with their cultural capital deficit, but they faced pressure from supervisors and hospital management to adhere to a fast-paced work schedule; and they wanted to bond with and offer extra care for coethnic patients, but they felt uncomfortable with the implication of favoritism.

Whereas the cross-functional professionals can resort to institutional autonomy and resources to deal with similar tensions, and the reformers and medical missionaries can do so by prioritizing, respectively, ethnic bonds and professional norms, the conflicted coethnics cannot articulate a consistent framework for integrating their ethnic and professional identities. Instead, they seem to invoke one set of norms or the other on an ad hoc basis.

Specifically, if conflicted coethnic nurses find a needy coethnic patient "deserving," they tend to expand the professional boundaries of care by redefining their relationship with the patient in pseudo-familial terms. They may feel critical of the coethnic patient's behaviors, but these behaviors also remind them of their own family and relatives. They therefore display extra patience in taking care of these coethnic—if admittedly challenging—patients and derive more emotional reward from doing so. Francesca described how she managed her coethnic patients' extensive "storytelling": "You ask the question and they come up with a long answer. If they're going and going and going, I just go, 'Okay. So does that mean yes or does that mean no?' [*laughs*]." But she also repeatedly said that she "worries about my Hispanic patients more," because "I know they will forget [to take their medicine]. Because my relatives in Mexico are like that." She regularly called these patients back to check on them and said that they reminded her of her own immigrant parents. Likewise, Nancy illustrated how conflicted coethnic nurses try to manage the communication styles of their less-assimilated coethnic patients, while reminding themselves to be more patient and accommodating:

> But this way of communicating through storytelling gets in the way of me doing my [job], me being more efficient with my time. I can see how I could get exasperated and just be like, "Okay, can you get to the point? Can you just answer my question?" At the same time, I feel like, I know that we [Hispanic people] communicate with stories. And I know that I get more information when they

> tell me stories. So, I hope that I'm not one of those people that get exasperated and cuts them off.

Laura described the way the familial nature of her patient relationships could complicate the line between her professional duties and her coethnic loyalties: "I felt like I'm taking care of my uncle. So that part was, yeah, and I was super-aware of it. . . . My boundaries were not really as sharp as they could have been."

At the same time, these nurses are anxious about letting such boundary expansion go too far; they worry about the situation becoming unfair, about letting these patients take advantage of the system, about the extra work for themselves simply becoming unmanageable. When a patient gives cues that trigger these worries, a "needy" coethnic patient becomes a "greedy" one. Nurses, in these situations, highlight their professional boundaries to fend off the "greedy" patient's "excessive" demands. Laura wanted to do more for her Latino patients, but also noted that their demands sometimes needed to be curbed:

> Sometimes they want more. . . . But you cannot give more because there's no more. We wish there was more to give, but. . . . As much as I want to, I can't today. . . . I remember one family, I moved everything for them. Like food-wise, I was ordering double portions so that they could eat, but then that was not enough. They wanted this specific soda, and these specific things. And I was like, "I gave you my hand and now you're taking my elbow, my shoulder, you're jumping all the way up." . . . Or also the sense of time, [they think] we have much more. The sense of time for Latinos, it's like a chewing gum.

Ursula was a Peruvian public health nurse whose workplace, the county's tuberculosis center, had several resources to help address patients' many financial constraints. Given the infectious nature of tuberculosis, Ursula persuaded her clients to be compliant using a variety of resources available to her, such as gift cards and travel vouchers. Her account illustrates especially well the dilemma of nurses who are committed to advocating for Latino patients yet feel obligated to draw the boundary between need and greed:

> I have to advocate more for the Spanish-speaking patients. . . . Like, I have to try to read what is in their minds because sometimes they are shy or they are embarrassed or they don't feel comfortable. . . . And of course there is the other extreme. The [Hispanic] people who want to take advantage of, "Oh, I'm in a private hospital. I want a double tray." Or the ones that ask for everything. "Give me soap." That's the other extreme. They are the ones who want to take advantage of the system, and we see that here also.
>
> There are situations where we have to pay for a motel because no one wants the patient. It happened a few months ago with one of my patients. Nobody wants the patient back home because the patient was infectious, so they can't [go home]. They had to pay for a motel, but only for a number of days. After that, the patient, if he or she is not infectious anymore, the patient has to find a place to go. But this person demanded, "No, you must find me a place to live or you have to find me a job." Oh, it's ridiculous! That's the other extreme.
>
> With those, we have to set limits. "I'll give you two gift cards and that's it." Or, "I'll give you three gift cards a week until you find a job. Once you find a job, I'll bring it down to one or two." And then they get mad. "No, why are you giving me less gift cards? I still need them." "Because you have a job. Because there are other people who don't have a job. They need more gift cards."

As richly illustrated here, Ursula had to know when to draw the line and limit the amount of resources she doled out to her Latino patients, whom she otherwise felt committed to advocating for. The task of defining need versus greed on a case-by-case basis is a source of tension for these nurses' workplace identity.

Furthermore, conflicted coethnics find their own biases and power struggles embedded in ethnic communities and cultures. Their sympathy for, and cultural affinity with, coethnics' values and cultural practices notwithstanding,

these nurses also think that professional distance sometimes protects patients from nurses' moral judgments about certain behaviors and can also serve as a defense for nurses against coethnic patients' internalized racism. (By the same token, professionalism protects Latina nurses from the ethnic biases of white patients and colleagues.) Further challenging a romanticized version of ethnic bonds in the clinic was the observation of some nurses that they felt excluded by other ethnic "relational communities" in the clinic. For example, several interviewees described feeling uncomfortable and unwelcome in their own work space when their Filipino coworkers became "cliquey" by speaking in Tagalog during work hours or otherwise blending professional and communal space.

Straddling their professional world and their ethnic community, and constantly on guard against one infringing on the other, conflicted coethnic nurses experience high workplace stress. Lacking a coherent workplace identity, they become very anxious when challenged by different groups to demonstrate where their singular loyalties lie: "Are you a team player with the rest of the doctors and nurses?" Or, "Are you too close with your people, and therefore a less competent nurse?" Or, "You are one of us; you are not really a medical professional."

The Sympathetic Outsiders: Spanish-Speaking White Nurses

Despite the policy focus on using minority health care workers as cultural brokers for coethnic patients, nurses who speak Spanish and self-identify as cultural brokers are not exclusively from Latino communities. Our study also includes four white Spanish-speaking nurses whose experiences accentuate the identity dilemma of the Latina nurses. In general, we find that the white Spanish-speaking nurses cared about their Latino patients' lifeworld constraints and were committed to helping these patients bridge the gap between their lifeworld and the clinic. However, their racialized outsider status provided them with a buffer between these challenges and their professional identity. They often described unresolved cultural tensions as part of "their culture," for instance, rather than as part of a shared experience.

The white Spanish-speaking nurses in our study seemed devoted to addressing Latino patients' lifeworld constraints, but they also described themselves as "bridge-builders" who understood aspects of Latino communities without being members of them. In their "bridging" efforts, they focused on the gap between "cultures of poverty" and biomedical priorities, deemphasizing the importance of ethnicity beyond language. They were critical of mainstream health care for making it difficult for all low-socioeconomic-status patients, not just Latino patients, to access quality care.

Instead of talking about ethnic solidarity or community empowerment, these white nurses characterized their relationships with Latino patients in terms of "rich cultural exchanges." (One nurse even talked about being more in touch with her emotional side in Spanish than in English.) Their self-positioning as sympathetic outsiders vis-à-vis Latino communities allowed them to avoid confronting certain tensions between patient lifeworlds and the clinic—for example, they saw the practice of bringing large families to the ICU as "their culture," which "I don't understand but respect." In contrast, Latina nurses facing similar tensions tended to feel pressured to state a position on what to do about "our culture." Unlike the Latina nurses, Spanish-speaking white nurses never talked about having to fend off overdemanding Latino patients. When asked about such patients, they said that their Latino patients "never complain" and "never ask for anything." Some of them observed that Latino nurses were pressured to distance themselves from unassimilated coethnic immigrants and that, being white, they faced no such pressure.

Although not the focus of this study, Spanish-speaking white nurses' experiences highlight the identity challenges faced by Latina nurses. Regardless of their ethnicity, all nurses in this study described tensions, many of them unresolved, between patient lifeworlds and the norms and regulations of the clinic. When self-positioning as outside helpers reaching out to the Latino community, the white Spanish-speaking nurses could look at the unresolved tensions as too deeply embed-

ded in "the community" to come within their professional reach. Such experiences exemplify the very stance that is *un*available to the Latina nurses. Identified as insiders in both their ethnic and professional communities, Latina nurses' workplace identities largely hinge on addressing the very tensions that "sympathetic outsiders" opt to bracket.

CONCLUSION

This study has examined how bicultural Latina nurses bridge patient cultures and clinical norms in performing their roles as cultural brokers for coethnic patients. Our findings indicate that these health care professionals cannot succeed in bridging the clinic and coethnic patients' lifeworlds without larger institutional transformations in place—for example, greater access to resources, more flexible institutional regulations, and an organizational culture committed to diversifying biomedical norms, as illustrated in the experiences of the "cross-functional professionals." Most of the Latina nurses in our study, lacking such structural support, had only several options: they were forced to internalize the cost (the "reformers within"); they became socialized into a narrow view of patient culture (the "medical missionaries"); or, as happened with more than half of them, they were left to struggle with institutional tensions as personal workplace problems (the "conflicted coethnics"). Overall, these Latina nurses' practices of code hybridization were often costly to their career (through, for example, difficulty with time management, disapproval from colleagues, doing extra work on their own time), but these practices often enriched the institutional culture of their workplace (for example, by creating richer understandings of patient lifeworlds and providing more room for relational bonds between patients and caregivers).

Our findings are likely to raise the question of *why* a bicultural nurse engages in a particular practice of code hybridization as opposed to another. This question lies beyond the scope of this article. Future research with a large and representative sample is needed to address whether and how immigrant generation, types of clinics, or other variables explain bicultural nurses' choice of code hybridization strategy. Here, it remains only to elaborate on the policy and theoretical implications of our research.

For policymakers, our study confirms that meaningful cultural brokerage in health care should focus on helping patients understand and situate health care procedures and decisions in their life contexts, and that such efforts on the part of health care providers require significant amounts of time, material resources, and a respectful and flexible institutional culture. Using immigrant professionals as cultural brokers will be a successful policy only if it also focuses on implementing relevant institutional changes. It is worthwhile to reemphasize our earlier clarification that "patient culture" is not simply patient ethnicity, but instead should be understood as a set of meaning-making schemas, shaped by intersecting social structures such as class, ethnicity, and immigration status. The Hispanic patient population discussed by our interviewees was by and large low-income and undocumented; these patients spoke little English and were more familiar with Latin American than North American cultures. Their sense-making schema for having to miss work to keep a medical appointment, for example, was not simply informed by being Hispanic, or poor, or non-English-speaking; it was precisely how these factors intersected in their lives that shaped their decision-making process. A Latina nurse may not automatically understand or sympathize with these patients' sense-making schemas, especially when working under pressure to adhere to mainstream professional norms. By the same token, a white doctor who speaks Spanish might learn to incorporate such lifeworld "cultures" into clinical communications (this possibility being, of course, beyond what our data can address). But more importantly, since current policy proposals continue to focus on ethnic concordance as a shortcut to addressing linguistic and cultural barriers in the clinic, it makes sense to improve upon existing policies rather than start from scratch. A sensible policy recommendation, we argue, is to give Latina nurses who are expected to work as cultural brokers the necessary institutional support, both cultural and material, to do so.

For scholars of immigrant labor market niches, our article offers a qualitative discus-

sion of the emergent niche of cultural brokers who facilitate the interactions between an increasingly diverse patient population and a white-dominant health care system. Our study highlights the social and cultural tensions faced by these cultural brokers, their familiarities with both languages and cultures notwithstanding. Our observations resonate with existing studies. For example, Ming-Cheng Lo and Roxana Bahar (2013) have found that Hispanic patients experience complex and tension-ridden relationships with coethnic nurses. Virginia Elderkin-Thompson, Roxane Cohen Silver, and Howard Waitzkin (2001) suggest that Latino nurses' social and professional standing might mitigate their willingness to advocate for coethnic patients or explain medical conflicts to their professional superiors. Advancing this line of conversation, ours is among the first studies to show that nurses can and do proactively address these tensions, with varying degrees of success, as illustrated in the patterns of code hybridizing reported here.

Furthermore, our findings have broader theoretical implications beyond the discussions of cultural competency policies and niche labor markets. The workplace experiences of our Latina nurses broaden the framework of segmented assimilation theory (Portes and Zhou 1993). As an extremely influential theory in recent debates about immigrant incorporation, segmented assimilation theory raises alarm about the danger of downward assimilation for the second generation of racialized minority groups, especially when immigrant parents and their American-born children adapt at different speeds (termed "dissonant acculturation" in this literature). In the context of this worrisome trend, it is particularly noteworthy that some minority immigrant children are observed to be protected against the danger of downward assimilation. Scholars argue that this happens when they adopt behaviors from the American mainstream that help them fit in, while retaining immigrant languages and cultural values, which work as a conduit for them to receive parental guidance and support (Portes and Zhou 1993). Described as "selective acculturation," this cultural blending has been shown to allow these immigrant children to reach parity with native-born whites and even surpass them in educational attainment and occupational status (Jiménez and Horowitz 2013; Kasinitz et al. 2008; Lee and Zhou 2015).

Our findings advance the segmented assimilation theory's argument in a number of ways. First, while this literature focuses mainly on school-age youths, our study is among the first to show how "biculturality" can function as a job skill for immigrant and later-generation adults. Mirroring the pattern of selective acculturation, our Latina nurses largely sought to make mainstream American institutional practices "work" for an immigrant population through the support of shared language and communal ties. But in this context, the elderly in the community were on the receiving end, not the giving end, of guidance and emotional support. The role of the cultural broker in health care—which is one of the fastest-growing industries in the United States—may be indicative of a growing market niche for bicultural professionals who can provide a bridge between predominantly white mainstream institutions and their increasingly diverse clienteles. Immigrants and their offspring are certainly not the only ones capable of becoming bicultural, but their experience of straddling both cultural worlds may predispose them to developing cultural blending skills.

Second, and relatedly, our findings illustrate how such cultural blending actually occurs on the ground. In the segmented assimilation literature, it is often assumed that children of immigrants, by virtue of being exposed to two cultures, naturally know how to blend them and resolve the tensions therein. To the extent that existing research has described concrete patterns of cultural blending, it has done so by and large in terms of "code-switching"—for example, adopting mainstream cultural styles at school or at work and switching back to ethnic cultural practices at home and in ethnic communities. Our study moves the discussion on the issue forward by challenging researchers to recognize that the boundaries between immigrants' social worlds are not always so clear-cut. With social boundaries becoming increasingly blurred, the practices of code hybridization are as important as they have been understudied.

Insights borrowed from the literature on black and Latino middle-class identities sup-

port the observation that cultural blending does not happen easily or automatically. As reviewed earlier, these studies suggest that middle-class minorities and immigrants engage in "code-switching" as a main strategy in straddling two cultural worlds. Sometimes middle-class immigrants establish ethnic professional organizations in order to have small cultural spaces where they can experiment with hybridizing both cultures. That the major mechanisms for embracing bicultural identity are code-switching and creating small cultural laboratories suggests that cultural blending *is not really happening in mainstream institutions*. It follows, then, that we have little understanding of how bicultural immigrants blend both cultures in mainstream institutions—in the rare cases where they do.

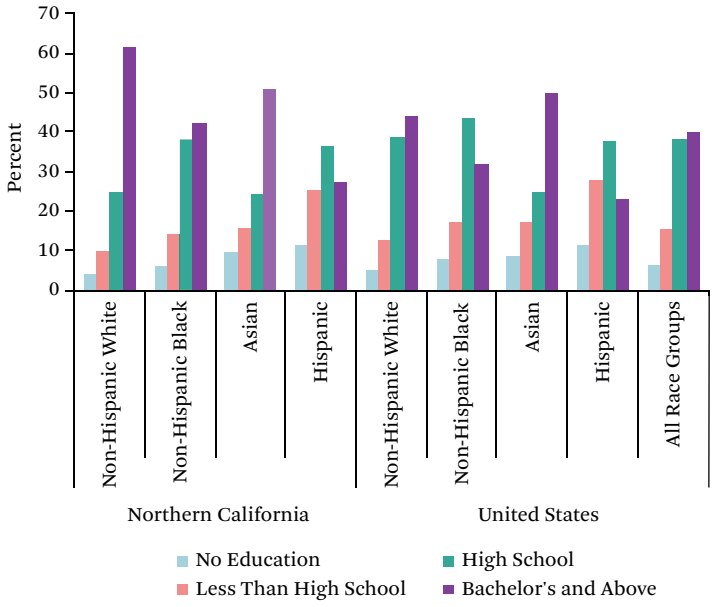
Our study offers an example of the diverse forms taken by code hybridization, with divergent impacts on individuals and institutions. The most robust practices of code hybridization not only empower both immigrant professionals and their clients but also engender critical reflections of institutional norms. But placed in an unsupportive workplace, code hybridization practices can become professionally costly for immigrant professionals. Other practices are lopsided, primarily reinforcing dominant institutional norms through a minority language. Being based on a case study, these findings are not meant to be generalized to other institutional contexts, but they do debunk the assumption that cultural blending happens automatically among bicultural immigrants and highlight the need for future research to focus on the patterns, potential, and limitations of various practices of cultural hybridization.

We must emphasize that, even as "biculturality"—achieved through selective acculturation, code hybridization, or other patterns yet to be uncovered—is proven to be an advantage rather than a barrier on the path to integration, integration is still fraught with challenges wrought by American mainstream institutions themselves. These institutions recognize the need to hire bicultural immigrants and their offspring as cultural brokers, but they rarely provide these individuals with the tools to achieve success alongside their non-immigrant coworkers. We have demonstrated, for instance, how the burden of the double duty—to achieve parity with white colleagues *while also* addressing their coethnic patients' needs—is put on Latina nurses themselves. We have also shown that occasionally institutions do provide such support, and that Latina nurses' bicultural skills can be best utilized when they do. Institutional contexts matter a great deal.

These findings suggest a cautionary note against the optimism that bicultural immigrants will automatically become agents of social change to usher in the new era of multiculturalism in mainstream America (Alba and Nee 2003). By the same token, these observations underscore that cultural brokerage, in its scope and importance, goes beyond how well immigrant professionals manage their workplace identities or help coethnic clients. Future research is called for to better understand how and why different forms of code hybridization take place and contribute to diversifying larger institutional cultures.

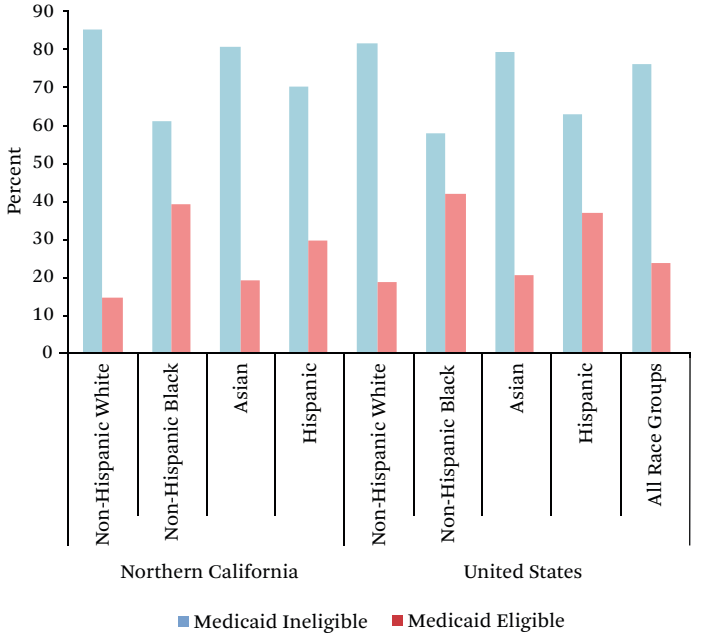
APPENDIX

Figure A1. Educational Attainment of Americans, by Race, 2012



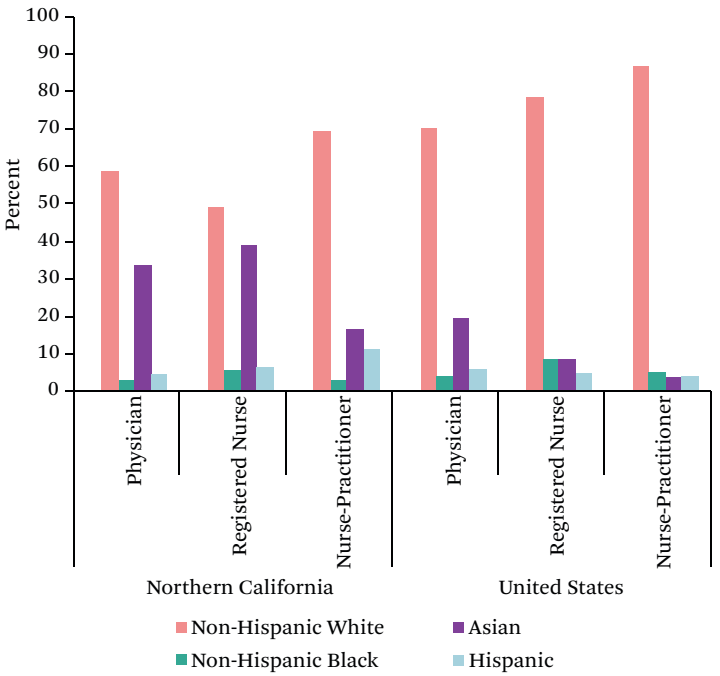
Source: Authors' calculations based on the 2012–2013 American Community Survey (ACS).

Figure A2. Medicaid Eligibility of Americans, by Race, 2012



Source: Authors' calculations based on the 2012–2013 ACS.
Note: Medicaid eligibility is based on income up to 133 percent of the federal poverty line.

Figure A3. Americans in Medical Occupations, by Race, 2012



Source: Authors' calculations based on the 2012–2013 ACS.

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