Getting In, Getting Hired, Getting Sideways Looks: Organizational Hierarchy and Perceptions of Racial Discrimination

Adia Harvey Wingfield[a] (ID)
and Koji Chavez[b] (ID)

Abstract

This article argues that black workers' perceptions of racial discrimination derive not just from being in the minority, but also from their position in the organizational structure. Researchers have shown that black individuals encounter an enormous amount of racial discrimination in the workplace, including but not limited to exclusion from critical social networks, wage disparities, and hiring disadvantages. But fewer studies examine the extent to which black workers believe racial discrimination is a salient factor in their occupational mobility or the factors that might explain their divergent perceptions of racial discrimination. Based on 60 in-depth interviews with black medical doctors, nurses, and technicians in the healthcare industry, we show that black workers' status within an organizational hierarchy fundamentally informs perceptions of the nature and type of workplace racial discrimination. These findings have implications for understanding how racial dynamics at work are linked to mental health, occupational satisfaction, and organizational change.

Keywords

race, discrimination, work, organizations

Researchers have documented that racial discrimination persists widely in U.S. society, creating disparities between black and white individuals in everything from life expectancy to educational access to wealth acquisition (Brown et al. 2003; Shapiro 2004; Tyson 2011). Given the ubiquity of racial discrimination in various settings, it is perhaps unsurprising that black individuals are more likely to believe that discrimination continues to exist and to affect them adversely. Perceptions of discrimination do not necessarily prove its existence, but self-reported assessments of this issue still matter because they can have broader implications for other aspects of quality of life (McKinney and Feagin 2003; Small and Pager 2019). For instance, blacks who perceive more discrimination have higher levels of stress and anger,

[a]Washington University in St. Louis
[b]Indiana University

Corresponding Author:
Adia Harvey Wingfield, Campus Box 1112, Department of Sociology, Washington University in St. Louis, St. Louis, MO 63130-4899
Email: ahwingfield@wustl.edu

which contributes to hypertension and other adverse health outcomes (Cose 1993; Lee and Turney 2012; Pavalko, Mossakowski, and Hamilton 2003). At work, feeling discriminated against often results in lower work commitment and job satisfaction (Ensher, Grant-Vallone, and Donaldson 2001). Perceiving workplace discrimination, moreover, is the fundamental first step toward addressing discriminatory practices through legal means, and thus it is highly consequential to companies and aggrieved individuals (Hirsh and Kornrich 2008).

Research shows that black individuals still perceive racial discrimination, but studies also show significant differences in how these perceptions manifest. For instance, a 2016 Pew survey indicates that blacks are split on what kinds of discrimination seem most salient. Among black respondents, 40 percent said "discrimination that is built into our laws and institutions" is more damaging than "discrimination that is based on the prejudice of individual people," and 50 percent argued that discrimination grounded in individual prejudice is more harmful. (Approximately 9 percent replied both, and 1 percent replied neither.) Perhaps more interestingly, the more educated respondents were, the more likely they identified discrimination built into structures as the larger problem. Thus, although black individuals agree that discrimination is an issue, they differ in their assessments of what type of discrimination presents the bigger barrier.

How can we explain these differences in perceptions of racial discrimination? Why would more educated black workers emphasize discrimination embedded in institutions over individual actors? Survey data indicate that education (and the higher incomes and occupational status that are usually correlated with it) does not preclude black workers from perceiving racial discrimination. However, these data do not offer clear insights into why we would see differences emerge in what kinds of discrimination seem to matter most.

We posit that organizations play an undertheorized role in explaining these differences in perceptions of racial discrimination. We argue that the variation in how black workers perceive racial discrimination is linked to organizational processes that inform where and how black employees observe racial discrimination. This article thus contributes to the emerging literature focusing on meso-level structures, and it builds on this theoretical work to explain differences in black employees' perceptions of workplace discrimination (Ray 2019; Sewell 2016; Wingfield and Alston 2014). We base our argument on a case study of the healthcare industry and draw from in-depth interviews with black healthcare professionals who are differently located in the organizational hierarchies of healthcare facilities—doctors, nurses, and technicians.

We find that position in the organizational hierarchy is linked to perceptions of racial discrimination. Doctors, nurses, and technicians are vertically ranked in the organizational hierarchy of healthcare facilities. They all reported that they encountered racial discrimination, but they described it differently. Doctors observed few cases of individual discrimination; instead, they contended that they were primarily subject to structural discrimination that spanned multiple organizations and organizational (as opposed to individual) discrimination within their workplaces. Nurses asserted that they faced organizational discrimination within their workplaces as well as individual discrimination from supervisors. Technicians cited frequent encounters with individual discrimination but were largely silent on organizational sources. By focusing on organizational interactions, we show that basic mechanisms, such as the process of attaining positions, navigating levers of organizational power, the effect of positional status, the ability to limit exposure to individual discrimination, and the role of status and power in interactions, are key to linking position in an organizational hierarchy to perceptions of racial discrimination.

In highlighting the significance of organizations, we integrate and further develop sociological theories of racial discrimination as well as organizational theories that emphasize

Table 1. Levels of Racial Inequality and Occupational Outcomes

Level	Focus of Analysis	Occupational Outcomes
Structural	Networks between multiple institutions (state, schools, neighborhoods)	Difficulty accessing "good" jobs and educational training; concentration in low-wage work
Organizational	Workplaces	Policies that maintain differential outcomes; tracking into "racialized" jobs; white space
Individual	Interactions	Differential treatment in hiring, promotions, and firing

how work sites are fundamentally racialized. We build on studies of discrimination to show it is not just race but position in an organizational hierarchy (and the attendant organizational processes) that informs how black workers perceive workplace racial discrimination. Additionally, we further develop racialized organizations theories by identifying how internal mechanisms explain why position in the organizational hierarchy leads to varying perceptions of discrimination.

THEORIES OF RACIAL DISCRIMINATION

As shown in Table 1, racial processes at an array of levels disadvantage black workers. Structural racism theorists posit that the processes perpetuating racial disparities are embedded in interlocking social, economic, legal, and political systems.[1] For instance, Bonilla-Silva (2001, 2018) argues that the United States is characterized by "racialized social systems" wherein covert, subtle processes that maintain racial inequality are legitimized by "colorblind ideology." Omi and Winant (2014) assert that racial projects occur through the political system in ways that have broad, far-reaching implications for other social institutions, including educational, social, and cultural systems. Feagin (2006) contends that anti-black racism is foundational to the United States, has been remarkably consistent over time, and is at the core of the country's legal, economic, political, educational, and social systems.

Structural racism theorists claim that differential access to resources in educational, political, and cultural systems leaves black workers at a disadvantage. Although these various systems may be decoupled or loosely linked, these theorists emphasize that the structural origin of racial discrimination means it is baked into virtually every segment of society, rather than being a tangential issue that can be fixed by reforming one or two systems alone (Feagin 2006). When it comes to work, this means that when black individuals, generally speaking, are concentrated in racially segregated, frequently stigmatized neighborhoods with lower-performing schools and higher rates of poverty, the racial dynamics embedded in each of these settings cumulatively create difficulties for accessing high-status jobs that lead to upward mobility (Pattillo 2013; Shapiro 2004). Furthermore, when jobs and other resources are not located in or adjacent to these neighborhoods, this can produce additional disadvantages for black workers in the labor market (Wilson 1987). Structural theorists thus argue that anti-black racism is so fundamental to U.S. society that, whether loosely connected or tightly coupled, institutions generally reproduce racial hierarchies and create disparate outcomes. The linkages between various organizations create a web of networks that perpetuate racial disparities in multiple settings (neighborhood, educational, social), and these result in myriad difficulties for black workers in accessing and keeping jobs.

At the organizational level, policies, regulations, and norms may be written to be race-neutral but ultimately have a disparate impact on black workers—what we call "organizational discrimination." Bonilla-Silva (2018) argues that these processes reflect the demise of the old "Jim-Crow style" mechanisms of racial inequality and the subsequent rise of colorblind ideologies that legitimize subtler, more covert practices that maintain racial disparities. For instance, companies that ban certain hairstyles for workers (e.g., dreadlocks, braids) are ostensibly creating policies that apply to all employees, but in practice have a disproportionate impact on black workers. Collins (1989, 1993) shows that in the wake of Civil Rights-era and affirmative action reforms, black executives encountered corporate procedures that channeled them into "racialized jobs" that were less integrated into the organizational structure, had less long-term security, and offered fewer trajectories to top management jobs (see also Stainback and Tomaskovic-Devey 2012). Organizational discrimination can extend to cultural practices and norms as well, such as when law schools represent a "white space" where conformity to certain dictates of legal thinking (constitutionalism, individual intent) leads to marginalization, hostility, and exclusion for students and faculty of color alike (Anderson 2015; Moore 2008).

Within organizations, individuals can also be active agents in perpetuating racial discrimination. We refer to these acts as "individual discrimination," inasmuch as they stem from individual prejudices. Individual discrimination is not necessarily mandated by policy but rather reflects an actor's discretion, personal beliefs, or preferences. For instance, even absent explicit organizational mandates, individual managers may (and frequently do) discriminate against black workers in hiring and promotion by showing more interest in white workers over equally qualified black ones (Pager 2003; Roscigno 2007; Royster 2003). As Bertrand and Mullainathan (2004) show, this kind of individual discrimination can even extend to names that appear to

signify black identity. Whether these decisions are a result of explicit prejudice (Feagin and O'Brien 2003) or implicit bias (Lieber 2009), they are a function of an individual's decision to treat workers differently (this individual decision may or may not be bolstered by organizational rules and norms). Ultimately, research shows a distinction between structural-level networks linking institutions that differentially allocate resources along racial lines; organizational-level policies that appear to be race-neutral but still disadvantage people of color; and individual-level behaviors and interactions that facilitate unequal treatment.

Perceptions of Racial Discrimination and Racialized Organizations

Given the structural, organizational, and individual disadvantages black workers encounter, it is perhaps unsurprising that they are generally underrepresented in many professional jobs. When they are the only one, or one of a very small minority in a work group, black workers frequently report encountering racial discrimination and exclusion (Stainback, Jason, and Walter 2018; Thomas et al. 2018). What do these assessments look like?

Mong and Roscigno (2010) find that black workers report workplace racial discrimination in the form of selectively enforced rules, overt racial harassment, and a higher likelihood of being fired or denied promotions. In Lacy's (2007) study of black elites, black professionals recounted racist slights from subordinates. And in Anderson's (1999) ethnography, black corporate workers said they observed racial discrimination from their white colleagues (although the manifestations of this differed by class). In a classic study by Feagin and Sikes (1994), black professional workers suggested that being black in predominantly white settings means fewer opportunities for advancement, being taken less seriously, and frequent disrespect from co-workers, clients, and supervisors. These workers described environments where differential treatment from managers flourished and proceeded virtually unchecked. Studies focusing

on black women at work show that they struggle to find white colleagues who will agree to serve as mentors or sponsors, especially when most of their peers and supervisors are white men (Bell and Nkomo 2003; Melaku 2019). In a study of workers situated in various occupations in the airline industry, Evans (2013) attributes black women's performance of emotional labor to the challenges associated with being in the racial minority.

Broadly speaking, the research shows that black people do perceive discrimination at work. However, we see two important gaps in this literature. First, despite the fact that racial discrimination occurs at multiple levels, most of the research documenting perceptions of workplace discrimination primarily highlights black workers' assessments of individual racial discrimination. Are black workers unaware of structural and organizational discrimination? Does it seem less significant than the individual slights they encounter? Or do they situate perceived individual discrimination in the context of broader social structures? The existing research does not generate much information about whether, how, and under what conditions black workers perceive other types of racial discrimination as factors that affect them. However, if black workers also observe structural or organizational discrimination (e.g., a perception that organizational rules are biased or that widespread racial barriers minimize their social mobility), then this could influence which kinds of interventions are most useful.

Second, the research that examines how black workers perceive racial inequality tends to assess this experience in a relative vacuum, often without attention to organizational structures. These studies highlight black individuals' assessments of racism at work (and in studies that focus on black women, consider how this is also informed by gender), but they tend to focus on the consequences of being in the minority. In other words, they attribute black workers' perceptions of (mostly individual) discrimination primarily to the experience of working in predominantly white environments. Little attention is

paid to the local organizational context in which these perceptions take shape.

Yet we know that organizations matter because, far from being neutral, objective structures, they are racialized sites themselves. In recent years, sociologists have advanced a theoretical model of racialized organizations that contends race is foundational to organizational structures, processes, and hierarchies (Ray 2019; Wingfield and Alston 2014; Wooten and Couloute 2017). These scholars argue that organizations can have an "identity," so to speak, that allows them "to be racialized in much the same way that people are" (Wooten and Couloute 2017:1). As racialized spaces, organizational beliefs, rituals, norms, and even language can serve to reproduce racial inequality. In this theorization, the racial character of organizations comes to reflect the populations they serve, so that "black" organizations like the Black Panther Party or historically black colleges and universities (HBCUs) coexist uneasily, and generally with far fewer resources and support, than "white" ones.

In a recent article elucidating a theory of racialized organizations, Ray (2019:26) argues that "race is constitutive of organizations" and that as racialized structures, organizations can minimize black workers' agency, differently allocate resources depending on where black workers are concentrated, and establish whiteness as a credential. Building on Acker's (2006) theory of inequality regimes and her argument that basic organizational practices uphold racial, gendered, and class disparities, Ray (2019) emphasizes how racialized organizations frequently reproduce inequalities. He defines these spaces as sites that "limit the personal agency and collective efficacy of subordinate racial groups while magnifying the agency of the dominant racial group" (Ray 2019:36). Like Wingfield and Alston (2014), he highlights the internal processes that perpetuate racial inequality within organizations. Ray (2019) also emphasizes that internal hierarchies map onto and reproduce racial stratification, with normative organizational procedures such as credentialing, interactional norms, and

job sorting used to slot workers of color into lower positions in the organizational hierarchy than white workers. Whereas Wooten and Couloute (2017) highlight the ways organizations can develop a racial identity, Ray (2019) focuses on the ways organizational processes actively maintain internal racial segregation and inequalities.

Theories advancing the concept of racialized organizations thus make several common arguments. They propose that organizations are structures built on inherently racial assumptions that then shape internal mechanisms, procedures, norms, and cultures. These theories highlight how, even in nominally integrated spaces, basic organizational practices, including but not limited to social closure, hiring processes, supervisory practices, exploitation, and everyday interactions, often perpetuate racial stratification and track white workers into higher-level positions than people of color (Acker 2006; Ray 2019; Tomaskovic-Devey and Avent-Holt 2019). Furthermore, in contrast to theories of structural discrimination that predict social systems (educational, political, economic) will consistently perpetuate racial inequality, theories of racialized organizations acknowledge there may be some variation between different organizations.

We extend the theories of racialized organizations by showing that position within an organization explains variations in perceptions of racial discrimination. Additionally, we highlight the organizational mechanisms that drive which kinds of racial discrimination black workers at different levels of a hierarchy find most salient.

RESEARCH SETTING: HEALTHCARE FACILITIES AS ORGANIZATIONAL STRUCTURES

We focus on healthcare to highlight perceptions of racial workplace discrimination. Conceptualizing the healthcare industry as a field offers a useful way to focus on organizations, their internal structures, and the ways they construct relationships with and between workers. Tomaskovic-Devey and Avent-Holt (2019:52) argue that all organizations are situated in "external fields such as markets, communities, [or] industries" that provide "meaning systems, legal and material resources and constraints, as well as the people who populate organizations." The healthcare industry thus serves as a field in which certain organizations are tasked with providing care.

These organizations can include hospitals, nursing homes, private practices, and clinics.[2] Some differences exist for each, but the various organizations in the same field share some institutionalized expectations and norms. Organizations that provide healthcare are usually bureaucratic structures governed by formal rules and hierarchies, with separate offices and divisions devoted to various tasks, and informed by the field's cultural ethos of providing care to patients, establishing billing practices, and dealing with insurance constraints. For instance, a hospital's emergency medicine department will include doctors, nurses, technicians, and other workers who are responsible for providing emergency care to patients. Such workers may have little personnel or task overlap with the staff in a neonatal intensive care unit, which would also include doctors, nurses, and technicians who focus on their particular specialty area.

Organizational Hierarchy of Healthcare Facilities

Healthcare facilities also function as an example of racialized organizations. In many cases, these sites have a long history of embedded assumptions about race, health, and medicine that reproduce racial inequalities within them (Hoberman 2012). Furthermore, they may take on a racialized identity as "white spaces" through cultural and normative practices, such as stereotyping black patients as noncompliant or downplaying their accounts of pain. Organizational structure can also reinforce how these facilities function as white spaces: although organizations in this field can take on different forms, in most settings they are firmly hierarchical. The layout resembles a triangle, with most

Table 2. Race and Gender Percentage of Medical Professionals

	Physicians	Nurses	Technicians
Black	5%	14%	13%
Male	2%	2%	4%
Female	3%	12%	9%
Non-Black	95%	86%	87%
Male	62%	10%	25%
Female	33%	76%	62%
Total	100%	100%	100%

Source: American Community Survey 2017 five-year sample (Ruggles 2019).
Note: Physicians include surgeons; nurses include registered nurses, nurse anesthetists, nurse practitioners, nurse midwives, physician assistants, licensed practical nurses, and licensed vocational nurses; technicians include clinical laboratory technologists and technicians, diagnostic related technologists and technicians, emergency medical technicians and paramedics, medical records and health information technicians, health practitioner support technologists and technicians, and miscellaneous health technologists and technicians.

workers subject to supervision and oversight from someone above. Jobs at different levels require varying responsibilities and qualifications, but internal processes such as credentialing, social closure, and wage-setting help maintain racial segregation across the organizational hierarchy. We focus on three skilled occupations in healthcare—doctors, nurses, and technicians—to highlight the hierarchies present in organizations in this field.

As racialized organizations that are very hierarchical and highly institutionalized, different healthcare facilities in this field are generally structured fairly similarly, which allows us to highlight the organizational processes that affect workers. Additionally, the hierarchical structure of healthcare facilities means jobs within the field are ranked in ways that reflect racial stratification, with black workers underrepresented in all three occupations but more so at the top than at the bottom.[3] These factors make healthcare a useful field site in which to assess variations in how black workers perceive discrimination, as well as the organizational dynamics that inform these variations.

Positions at the top of the organizational hierarchy tend to be predominantly filled by white men; they offer higher status, income, and prestige. When it comes to patient care, within the organizational structure of most healthcare facilities, doctors occupy a position at or near the top, followed by nurses, and then technicians (see Table 2). Of course, these occupational categories contain subgroups—even among doctors, surgeons enjoy more status, higher wages, and greater prestige than pediatricians (Cassel 1998). And although healthcare workers engage in collaborative teamwork (e.g., doctors will work with nurses, physician assistants, nurse practitioners, and technicians to provide patient care), the institutionalization of the organizational structure means that in most facilities, the division of labor, authority, control, and resources are allocated in ways that prioritize doctors over nurses and nurses over technicians. Thus, although doctors occupy a higher position in the organizational structure than nurses, hierarchies persist within and across occupational groupings.

Situated at the top of the organizational hierarchy, doctors are employed in jobs that offer the most security, stability, pay, and status. Physicians are also disproportionately white men. Women of all races constitute 36 percent of doctors, and black doctors (men and women) total a paltry 5 percent. This is due to a confluence of many factors, including but not limited to processes of social closure, structural racial and gender discrimination, and more recently, a culture of overwork common in professions dominated by men (Bhatt 2013; Boulis and Jacobs 2003; Cha 2013; Cooper 2000).

Nurses are positioned in the middle of the organizational hierarchy. They have less status, pay, and influence than doctors. Unlike physicians' work, nursing has long been characterized as a feminized job; white women make up 67 percent of the workers in this profession, compared to black women's 14 percent. These demographics persist due to mechanisms of social closure wherein men of color are excluded and white men in the profession distance themselves from their women colleagues (Williams 1995; Wingfield 2009). Consequently, there are more women working as nurses than as doctors, but structural and institutional processes (e.g., barriers in hiring and education) mean black women remain underrepresented in the profession, and black men even more so.

Finally, of the three occupations discussed here, technicians are at the bottom of the hierarchy. Technicians are also primarily women, although the occupation has not had the same long-term gender segregation as is found among physicians and nurses.[4] Yet, as is the case for professions dominated by women, technicians receive lower wages and have less status and prestige than doctors and nurses, due in no small part to the processes of social closure and credentialing that occur in the aforementioned professions. Nurses can and do delegate tasks to technicians. Thus, social closure among nurses and doctors, coupled with wage-setting, leaves technicians subject to lower pay and status than those above them in the organizational hierarchy. Few studies explicitly examine racial issues among technicians, but it stands to reason that issues present in other occupations (e.g., reliance on social networks in hiring, the "white space" that characterizes organizations) help explain why black workers are also underrepresented in this profession.

DATA AND RESEARCH DESIGN

Our analyses draw on intensive, semistructured interviews with 60 black workers employed in the healthcare industry. Respondents worked in professional occupations that

Table 3. Respondent Gender and Occupation

	Male	Female	Total
Physician	13	13	26
Nurse	12	11	23
Technician	4	7	11

Note: All respondents are black.

required at least some formal, specialized training. Twenty-six were doctors associated with various specialties, 23 were nurses or physicians' assistants, and 11 worked as technicians (see Table 3). Respondents worked in a variety of settings, from private practices where they primarily saw privately insured patients, to large hospitals that struggled for funding and served predominantly poor black and Latino populations, to teaching hospitals that served mostly white, upper-class patients. Respondents represented a variety of geographic areas and urban, suburban, and rural locations across the United States. Our sample was not random but was designed to maximize variation in experience within each occupational group.

We used a variety of methods to locate respondents. Principal among these was snowball sampling, wherein we asked respondents to refer other people they knew who might be interested in participating in the project. This strategy is particularly useful for locating respondents who are underrepresented in certain fields (e.g., black men in nursing). We also contacted several professional associations, described our research, and solicited respondents through their membership networks. Finally, in other cases, we simply approached respondents through "cold calls," in which we researched faculty web pages or LinkedIn profiles and emailed individuals to ask if they would be interested in being interviewed.

During the interviews, we asked respondents a number of questions about their trajectories into healthcare, their daily routines at work, and whether they believed race affected their work lives (and if so, how). We also asked them about major changes happening

in the healthcare industry and the impact these changes were likely to have on black workers in their profession. Specifically, we asked them about the increasing numbers of women in medicine, the rise of cultural competency, efforts to diversify the profession, projected practitioner shortages, and the Affordable Care Act (ACA).[5] We also questioned respondents as to whether there were other major changes happening in healthcare that they believed could affect their work.

All interviews were conducted in person or on the telephone and audio recorded unless the respondent would not agree to it. In those rare cases we took detailed notes, which we typed up immediately after the interview. Telephone interviews took place at a time of the respondent's preference and followed the same semi-structured format as face-to-face interviews. When interviews were conducted in person, they took place in our offices, the respondent's office, or in a neutral location such as a coffee shop. Audio-recorded interviews were later transcribed for coding purposes. Data were coded according to themes that emerged inductively. Thus, we were able to identify patterns that emerged in the data: doctors' versus nurses' descriptions of racial incidents, black men versus black women doctors' accounts of how race affects their work, challenges facing doctors who work in underfunded public hospitals versus those at well-funded university locations, and so forth. All respondents quoted in this article are identified by pseudonyms.

In addition to interviewing, the first author also engaged in field observations at three sites. One was a large public hospital that served a predominantly black population. The first author was granted permission to observe interactions in the internal medicine department. The hospital staff in this department was the most multiracial of the three sites, with a handful of black, Latina, and Asian American doctors and mostly black nurses and technicians. The second site was a mid-sized private pediatric practice where the staff and patients were predominantly white. The third site was a large, well-funded university hospital, where the first author observed interactions in the obstetrics/gynecology wing. The doctors and nurses on staff were predominantly white, and technicians were mostly black. The first author spent about three weeks at these locations to observe doctors, nurses, and technicians at work. In shadowing doctors in each setting, the first author was able to observe multiple interactions among staff and between staff and patients in order to collect additional data about healthcare practitioners' everyday work routines.

By selecting these particular locations, we were able to assess everyday workplace practices in three very distinct healthcare facilities. Hierarchical relationships between focal occupations were the same, but there was some organizational variation. The public hospital highlighted how the decline of resources devoted to the public sector has affected patients and workers alike; the university hospital underscored the tensions present in more well-funded locales that serve predominantly poor patients of color; and the private practice offered a glimpse of how black women doctors navigate work environments where both patients and co-workers are overwhelmingly white and well-off. Field observations in these three settings offered some insights into whether organizational variation informed the content and degree of black workers' perceptions of discrimination.

FINDINGS

We first compare how black doctors, nurses, and technicians perceive racial discrimination at work. Following this, we analyze how black workers' position in the organizational structure—with doctors at relatively high positions, technicians at relatively low positions, and nurses in between—informs the organizational processes to which they are exposed and thus their perceptions of which types of racial discrimination are most salient for them.

Black Doctors: "The Difficulty Is Getting In"

Prior research describes black workers' routine, constant encounters with racial slights

and incidents of overt harassment (Evans and Moore 2015; Feagin and Sikes 1994), but black doctors in this study said this is not an accurate description of their work lives. They characterized individual racial discrimination as an occasional phenomenon, and most could point to only one or two times when they encountered racial discrimination in interactions with someone in the workplace. Edward, a surgeon, stated, "I can think of one time when I was working in the ER and God bless him, there was a fellow who came in who was piss drunk, having chest pains, had no insurance. . . . He comes in and decides he wasn't gonna let no nigger doctor take care of him. So, he fixed me by getting up and walking out. [But] *it's extremely rare for me.* I think that may have been one of only two experiences that I've had in 30-something years of white patients that were negative" [emphasis added]. A pediatrician, Janelle, concurred, stating, "You might sometimes hear an open-ended comment [where people seem to second guess you] but you could take it either way. [They might say] 'Are you sure about that?' 'Do you really want to do that?' But that's rare. I can't say that I've had experience after experience where it's been like just because I'm a black female, I'm being treated differently." Larry, a neurosurgeon, said, "I certainly can tell you that I've been on the board of the Physicians' Alliance for the past 15, 20 years. And I've been well received and well respected and I've always been welcome. And that is not a black organization, that is an organization. In other words, there are whites, blacks, Hispanics, and everyone else. We work well together, there have been no issues, there have been no barriers to my success there."

In general, black doctors described the workplace as a positive environment in which they perceived few racialized encounters with co-workers or patients. They largely characterized those kinds of encounters as rare and unrepresentative of their general experience in medicine. The sole, but notable, exception to this came from emergency medicine doctors in hospitals that served predominantly white patients. These respondents were much more likely than doctors in other specialty areas and settings to observe overt and sometimes hostile individual discrimination from their white patients. Charlie, an emergency medicine doctor, said, "Just a few weeks ago a patient came and said she doesn't want to see a black doctor. She said only a white doctor." Jaden, chair of an emergency medicine department, echoed this sentiment. He noted, "I've experienced hearing racial slurs from older white patients. It happens. I just take the high road." Some organizational variation was present: emergency medicine doctors in hospitals that frequently treated white patients recounted more individual discrimination from patients.

Most black doctors perceived individual racial discrimination as a rarity, and they argued that structural and organizational discrimination is more commonplace and has more of an impact. When it comes to identifying structural discrimination, doctors highlighted the racial barriers for black students in the educational pipeline, which limit the number of black doctors in the medical profession. They thus connected racial barriers in the educational system with racial disparities in the practice of medicine. Morris, an internal medicine doctor, asserted that he had benefitted in his own career from a combination of hard work, early interest in the field, and attending a medical school that made a targeted effort to create more racial diversity. But he also described the broad racial and class discrimination poor kids and black kids face in educational settings. When asked to share ways he felt race had an impact on black doctors, he replied: "The difficulty is getting into the undergraduate institutions. It's getting difficult. It's getting very, very, very difficult. I was just reading an article about this. It talked about rich kids and poor kids, but most of the poor kids are typically black. It's a very interesting article about the impact of how undergraduate schools are going to be changing so that pool is distinctly changing. Because I think a lot of kids coming from underserved areas are being discriminated against." Shuri, a dermatologist, agreed with these sentiments:

"It seems that there's just less black physicians going into medical school [despite] the opportunity [being] there. The medical school I attended, we had approximately 160 or 170 students in our class. There were only five of us who were black. I just think that from the front end, the preparation for getting into medical school might not be there to help blacks get into medical school. So, I think that just kind of limits the number that are actually there." Shuri is partially correct about the decline in black students' enrollment in medical schools in that numbers have dropped among black men—they were 35 percent of black medical school graduates in 2015, down from 57 percent in 1986—and from her standpoint, this decline is attributable to structural factors, such as subpar educational preparation, that keep black students underrepresented in medical schools and ultimately in practice (Laurencin 2018).

Structural discrimination in educational settings was compounded by factors at the organizational level. Here, black doctors identified discrimination in the hiring process for physicians. They argued that this emerged primarily in the weight given to candidates' personal connections. Caroline, an oncologist, asserted that her white colleagues' tendency to want to hire people from their in-groups made it harder to recruit and retain colleagues of color. A former colleague referred her for the job she currently held, but she noted that was unusual for black physicians. More commonly, Caroline felt that her colleagues sought to hire well-connected white peers. She told the following story of the hiring process for a competitive fellowship:

> I was thinking to myself when we were going through all of the fellowship applications, "Why are we giving this girl a spot?" I mean, nobody reviewed her application, really. I don't remember what her STEPs scores were—that's her standardized licensing scores, which weigh heavily into your fellowship. I said, "Why are we giving this girl a spot?" I didn't even know what she looked like. I had never worked with her

before. But it was almost like a given that she was to come here. And so I said, "Well, we only have three spots. We've got a hundred applicants. Why are we giving this girl a spot?" "Well . . . she's the chief resident, she trained here, she needs a spot." . . . The same was with another white guy who was given a spot. His dad was one of the professors in the radiology department, and he had a horrible personality. So, I was like, "This dude has no personality, y'all. Unless he's like Albert Einstein and he's got the newest cancer drug, move on." And they were like, "No, he's got one of our three spots." I said, "Let's review here. We're giving two spots to people without reviewing their applications so really, everybody else is competing for one spot. One?" And they were like, "Yep."

The advantage of personal connections for white doctors was a common theme among black doctors. During the first author's field observations, one black doctor pulled her aside to remark on the conduct of a somewhat assertive resident: "Did you see that guy back there? Yeah, his dad is the chief of staff for [names adjacent hospital]. I'm not saying he doesn't deserve to be here necessarily. He's fine. But we all know who his father is. And that has clearly made his life easier." Reading between the lines, this doctor suspected that personal connections were an integral part of this colleague's access to and entry into medicine.

Black doctors argued that these structural and organizational processes minimized the numbers of black doctors. Importantly, they also argued that the low numbers of black physicians adversely affected their own occupational mobility. For many black doctors, their stark underrepresentation meant fewer potential mentors who shared their professional interests, especially when these interests centered on reducing racial health disparities. They did not categorize this lack of black mentors as a consequence of individual discrimination in the form of potential (white) mentors making intentionally or implicitly biased decisions to avoid working with them.

Instead, they framed the dearth of black doctors as a consequence of a broader confluence of structural and organizational factors, and they concluded that the low numbers of black doctors minimized their access to black mentors who shared their thoughts about the importance of acknowledging race in healthcare. Annette, a surgeon, noted, "There has not been an active movement [in my field] behind [reducing racial disparities], so you don't have a lot of people who are engaged in that type of research or that type of care. It's not something that's ideally in the practice that they've established, so it takes quite a bit of convincing of people to help them realize the importance of the work that I do." She acknowledged that the difficulty finding mentors interested in racial issues in health continued to impair her career advancement.

In general, black doctors did not believe they were significantly affected by individual racial discrimination at work (although emergency medicine doctors who typically treated white patients identified starker and more frequent examples of individual discrimination). Instead, black physicians argued that the kinds of workplace discrimination that affected them were shaped by structural and organizational processes—namely, in the educational pipeline to becoming a doctor, hiring decisions, and developing mentoring relationships. These responses were consistent from both black men and black women physicians. Despite the fact that medicine is a culturally masculinized profession, the overrepresentation of men in the field did not lead to differences in how black women and men perceived racial discrimination.

Black Nurses: "A Harder Time Getting Hired"

In contrast to black doctors, black nurses said that when they encounter racial discrimination at work, it occurs at both the organizational and individual levels. Black doctors observed individual discrimination infrequently enough that they characterized it as a rare phenomenon, but black nurses routinely

perceived discriminatory behavior in everyday interactions. Sometimes this occurred in interactions with white patients, such as when Susan, a family nurse practitioner, described a patient who undermined her authority by stating, "I want to speak to your supervisor because you can't be too high up on the totem pole." Organizational variation emerged here as well, as black nurses in facilities that primarily treated white patients cited more cases of perceived discrimination.

We do find consistency across organizations in black nurses' perceptions of individual discrimination from colleagues. Across multiple facilities, black nurses asserted that discrimination occurred during interactions with white nurses who worked in supervisory roles, and it was usually linked to racial stereotypes and differential treatment. Teyana, a nurse who worked on the delivery floor of a hospital, described how her supervisor turned misunderstandings into racialized events:

> I was in my patient's room and I come out to the desk because I needed to call the doctor. The charge nurse was sitting there slamming stuff around and putting stickers on stuff. And I said, "Oh, did we get another patient?" She was like, "Yeah, I just delivered your patient." I said, "*My* patient? . . . I don't have another patient." She said, "Yes you did. But we couldn't find you." I said, "I was right here in this patient's room I've been in and out of all night." Nobody told me that I was next up for a patient, because it happened so fast. Well about a week later, the nurse manager over the whole unit called me into the office, and she had this long write-up from not only that charge nurse, but another charge nurse. It said that they can't ever find me on the night shift, and that I get warm blankets out of the warmer and go to sleep at the nurse's station.

Teyana asserted that such baseless accusations are part of a workplace where interactions with supervisors frequently involve excluding black colleagues, doubting their capabilities,

and subjecting them to differential treatment. ER nurse Melissa offered a similar account, recalling a period during her training when she stayed past the end of her shift to help a white nurse put a catheter in a patient. After Melissa went home, "the nurse apparently went back to the charge nurse and said something about how I didn't want to work and she didn't like me because I just left without saying anything and just abandoned the patient." Melissa lamented that the nurse supervising her attributed her actions to unprofessionalism, a poor work ethic, and the belief that she was simply lazy and lacked seriousness—interpretations that are consistent with racialized stereotypes about black workers.

Nursing is a culturally feminized occupation composed predominantly of women, but black men working in the field reported similar perceptions of frequent individual discrimination. Grant, a trauma nurse, offered a particularly jarring example of overhearing colleagues using racial slurs in his presence: "I've heard somebody say some off-color jokes and that's the thing—they think it's a joke. And I'm sitting, listening to this, I say, 'What the heck did they think?' You use the N-word in reference to—traditionally you'd try to use it towards black folks, and they are comfortable with saying it?" Grant described this as a run-of-the-mill occurrence. Another nurse, Dexter, noted how interactions with supervisors were, as his women colleagues described, a frequent source of individual discrimination. Dexter described several "run ins" with white women charge nurses in a previous job. In one instance,

> They said, "We're going to write you up because we were told that a 6'3 African American man was on the phone during working hours with blue scrubs, and we assumed it was you." I thought it was a joke. And I said, "No, I don't usually talk on the phone outside of the department." They said, "Well, but you were talking during working hours, when you were supposed to be at your duty station, and we've been a little bit concerned about your work ethic."

And so I was immediately taken aback, because no one had communicated to me about my work ethic, other than that it was great and I had worked really hard, and people were happy with my work ethic, and I assumed that my review was going to go well and I was going to get a raise. So, I was very much taken aback by that.

Black nurses were far more likely than black doctors to perceive individual discrimination, but like black doctors, they identified organizational discrimination as well. Black nurses also argued that organizational discrimination occurred in the hiring process, particularly as candidates relied on social connections to gain access to jobs. Describing the importance of social networks in hiring, Maureen said: "Black nurses have a harder time getting hired than white nurses do. So, when jobs pop up, typically they're going to go first to people that they know or to those people that the hiring person knows. When a job opens, who's going to hear of it first if the first people to hear of it are going to hear of it via word of mouth? That's usually word of mouth from people that you're in network with."

Other nurses asserted that the hiring process was a site of organizational discrimination because of the way the credentialing process itself can have divergent implications for black applicants. Yasmin, an emergency room nurse, argued that racialized credentialing disadvantaged black nurses during hiring. She said, "I think the opportunities are there, the jobs are there. But I think employers really tend to focus on the school that you went to, your grades, your references, the strengths of your references, and in particular, the school because the school makes a huge impact on what the employer sees as a good nurse or not such a good nurse. . . . If they saw that a black woman went to Norfolk State versus a black woman that went to UVA, they're going to draw some conclusions. I wouldn't be surprised if it begins to happen with a lot of HBCUs and with community colleges." Similar to the racial consequences of social networks, Yasmin highlighted how

devaluing graduates of historically black colleges and universities can create a barrier for black nurses at the point of hire. Unlike the doctors in the previous section, Yasmin did not identify discriminatory processes in educational systems that then have implications for nursing. Rather, she situated discrimination within organizational processes, in particular their hiring procedures, to emphasize how the focus on credentialing implicitly disadvantages black candidates.

Black Technicians: "The Face Tells Many Stories"

In contrast to black doctors and black nurses, black technicians shared few accounts of structural or organizational discrimination. Instead, they emphasized individual racial discrimination, and argued that it typically presents during interactions with nurses and patients. Organizational variation is consistent here with the accounts from doctors and nurses: black technicians employed in facilities that treated more white patients shared more observations of individual discrimination in interactions with them.

Marcus, a trauma technician, noted that sometimes white patients or their families will object to a black technician's efforts to perform basic procedures. When asked if that has ever happened to him, he replied, "The bulk of the time, the answer's yes. [White patients will request someone else.] There's probably about 70 percent. Probably about 70 percent of the white patients that I see ask that question, and I have to go through that process." Derron, a technician in an oncology department, described subtler accounts of individual discrimination: "When I walk into a room, I get these looks that I can read—'who is he, what is he here for,' and the looks are incredible. . . . The white people look at their family members and give them a side-eye look out the corner of their eye and they're a little surprised. The face tells many stories. It's a shock[ed] look on them."

Whereas Derron offered a subtle account of individual racial discrimination, Keisha described a more blatant case that transpired when she entered a room to perform a routine test on a patient's newborn baby:

> When I came in, I did her vitals, and then I asked her could I take the baby, and I told her I would be back in about 10 minutes. And her dad started going off, because she was handing me the baby and he was like, "What are you doing?" And she was like, "Oh, Dad, please don't start," and he was like, "You don't know who she is. She's just coming in here, grabbing the baby, and she could be anyone. Look at her!" I looked at him, and I'm like, "Well, here's my badge." My badge had flipped around, so I turned it around, and he was like, "That's the problem here. They'll let anyone work here. You people are lucky to be here!"

For Keisha, this father's response, and particularly his use of the loaded phrase "you people," was an example of the type of individualized racial discrimination she faces in her role as a technician. Keisha further asserted that individual discrimination of this kind—interactions with patients who casually express doubts and concerns about black workers' skills and expertise in ways that rarely seem to present themselves with white workers—is commonplace for black technicians.

In addition to dealing with patients, black technicians said they faced individual discrimination from people directly above them in the organizational structure. In most cases, this meant they encountered individual discrimination when interacting with white nurses. Mona, a technician at an ob/gyn's office, believed she faced individual discrimination from a white nurse who would eventually work above her:

> We had one nurse that was Caucasian and it, like, changed the whole atmosphere of the office because she was uptight, so we all were uptight. There was not a lot of smiling faces. [When I interviewed with her], first thing she said to me is I should have come with a business suit on. And I started

laughing, like, why I'm going to come with a business suit on and everybody else in the waiting room don't have on a business suit either? You don't have on one and neither does the other young lady I spoke with on the front desk. But I did excellent on this interview and that's what shocked her. But [she was] looking for somebody who looks a certain way, and I don't look that way. This woman even said something about I need to go on a diet to lose some weight.

Based on this initial interaction with her future supervisor, Mona believed racial bias informed the interviewer's reaction to Mona's appearance, displays of competence, and dress. Her perceptions were based on her observation that this nurse treated her differently from white applicants, and later, white colleagues.

In their position in the organizational hierarchy, technicians interacted with doctors much less than with nurses. In the event that they did have unpleasant interactions with doctors, technicians usually did not categorize these as examples of discrimination. Rather, they asserted that doctors could be short and terse with everyone. Consequently, black technicians usually did not believe that poor treatment they received from doctors was necessarily indicative of individual discrimination. As Sonia put it, "Doctors are just rude to everybody. Honestly, I can't tell you of a situation where a physician was unduly rude or nasty to me because of my color. They are just rude people, period." Doctors' brusque treatment could be intimidating and upsetting, but it was at least consistent with how black technicians saw others being treated, and thus they did not view it as an example of discriminatory behavior.

Technicians' work is not as historically or culturally gendered as medicine or nursing, and results do not indicate gender differences in how black women and black men perceived racial discrimination. Overall, both believed they encountered individual racial discrimination when treating patients and interacting with nurses.

ANALYSIS

What explains why black healthcare workers have such different perceptions of racial discrimination? Our findings indicate it is not just being black in a predominantly white environment, but one's position in the organizational hierarchy that indicates whether *structural* (occurring across multiple interrelated institutions), *organizational* (embedded in the rules and norms of an organization), or *individual* (prejudice during social interactions) discrimination becomes more or less salient. We argue that at different levels of the organizational hierarchy, workers are exposed to various processes that shape which kinds of discrimination seem most salient (see Table 4).

Black doctors, who are highly placed in the hierarchy of healthcare facilities, focus much more on the ways structural and organizational processes create racial disparities in the profession. In contrast, black nurses, who occupy a lower place in the hierarchy, observe both organizational and individual racial discrimination. Black technicians, who are still lower in the organizational hierarchy, mostly perceive individual discrimination but do not highlight organizational or structural discrimination. These perceptual differences are linked to position in the organizational hierarchy and the organizational processes to which black workers are exposed at these levels.

Mechanisms That Facilitate Different Perceptions of Discrimination

What activates black healthcare workers' perceptions of when structural, organizational, or individual discrimination is occurring? The theory of racialized organizations suggests that everyday procedures such as credentialing, the allocation of resources, and distribution of workloads reproduce racial inequality. We extend these theoretical arguments by introducing four mechanisms that connect hierarchical position with black workers' perceptions of racial discrimination: attainment of the position, navigating organizational levers of power, effect of positional status on exposure

Table 4. Positions in the Organizational Hierarchy, Exposure to Organizational Processes, and Types of Discrimination Perceived

Profession	Level in Organizational Hierarchy	Organizational Processes	Type of Discrimination Perceived
Doctor	Top	Credentialing; hiring; supervisory practices	Structural, organizational
Nurse	Middle	Hiring, everyday interactions	Organizational, individual
Technician	Bottom	Supervisory practices, everyday interactions	Individual

to others, and use of status and power in interactions. These mechanisms help explain why black doctors, who are highly placed in the organizational hierarchy of healthcare facilities, focus more on the ways structural and organizational processes create racial disparities in the profession than on individual racism; why black nurses, who occupy a lower place in the hierarchy than doctors, observe both organizational and individual racial discrimination; and why black technicians, who are still lower in the organizational hierarchy, mostly perceive individual discrimination but do not highlight organizational or structural discrimination. Within racialized organizations, internal processes do more than just perpetuate inequality. They also inform the type and nature of racial workplace discrimination that black employees observe.

Attaining positions within the organizational structure. Since Weber (1921), sociologists have recognized that higher positions in an organizational hierarchy often require more qualifications for entry. For Weber (1921), this relationship ensured that the most competent workers held the most important positions, at least in theory. Later scholars downplayed the strict relationship between qualifications and competence, arguing that increasing qualifications represented artificial restrictions on the supply of eligible workers (Weeden 2002) or an organizational need for legitimacy (DiMaggio and Powell

1983). No matter the underlying reasons, positions higher in an organizational hierarchy require greater credentialing in the form of educational requirements, certifications, proof of specific knowledge through exams, or relevant work experience.

The organizational structure of healthcare facilities is a good, if not extreme, example of the relationship between hierarchical position and the qualifications required to enter those positions. Although the specific requirements vary by specialty, physicians are generally required to have extensive educational backgrounds, practical experience, and certifications of institutionalized medical knowledge. Doctors must complete medical school, which itself requires graduating from a four-year university and passing the Medical College Admission Test (MCAT). After medical school, doctors develop practical knowledge through residencies. To enter residency, medical students must pass the first two stages of the United States Medical Licensing Examination (USML), and they must pass a third stage to graduate from residency. Medical students must then pass their board certification to enter the medical profession. Attaining a position as a medical doctor requires years of education and training.

Becoming a doctor in a medical facility means having personal experience in acquiring the credentials, education, and training required for that position. For black doctors, this process of credentialing engenders intimate

knowledge of how structural discrimination spans various settings, including educational and training processes (for historical perspective, see Baker et al. 2008, 2009; Washington et al. 2009). Unlike black nurses and black technicians, black doctors' extensive, lengthy credentialing process exposes them to multiple ways potential black doctors can encounter discrimination in various educational settings: black students, for instance, have fewer opportunities to take relevant courses (Carmichael et al. 2006), fewer mentors and role models (Alfred et al. 2005), face racial tokenism and stigma (Chang et al. 2011), and have less cultural knowledge in navigating medical education (Lareau 2015). Furthermore, the extensive education doctors undergo for their training may equip them with the tools to identify and name the organizational and structural discrimination they observe. Shuri, the dermatologist, recalled her own experience in medical school to describe how racism in medicine is a structural process. Black doctors drew on their lived experience to stress how racial discrimination across education, training, and work produced racial disparities in their profession.

Nurses and technicians also undergo credentialing, but it is nowhere near as extensive as what doctors experience. For many years, an associate's degree could suffice as a qualification for the nursing profession, but as many nurses in this study asserted, minimum expected standards are now increasing. Many organizations now require nurses to hold at least a bachelors' degree in nursing and to pass a licensing exam. Many technicians can still practice with an associate's degree. Ultimately, although nurses and technicians go through credentialing procedures, we suspect the shorter duration of these processes means their pathways do not draw as much attention to structural discrimination that spans the organization and extends to other related settings.

Navigating organizational levers of power. Positions higher in the organizational hierarchy have more control and responsibility over the institutionalized rules and norms that affect workers within the organization (Astley and Sachdeva 2011; Diefenbach and Sillince 2011; Weber 1921). In medical facilities, doctors are involved in hiring other doctors. In private practices, they may also be involved in hiring nurses, although in larger settings like hospitals, charge nurses may have some say over hiring other nurses and technicians. Of these three categories, technicians are likely hired by managers and have the least knowledge of and influence over hiring decisions. Black healthcare workers who make personnel decisions like hiring are more intimately aware of how organizational rules and norms for those decisions have intentional or unintentional racialized effects (for racial effects of hiring rules and norms, see Bills, Di Stasio, and Gërxhani 2017).

Black doctors, and to a lesser extent black nurses, are more likely than black technicians to recognize organizational discrimination because of their direct participation in hiring and selection processes. For Caroline, the oncologist, experience in evaluating and hiring new doctors made it clear how the institutionalized practice of relying on personal connections disadvantaged black applicants. In one instance, she "had to beg" to get a black woman, "who was the most qualified out of everybody" but lacked the personal connections, into the program.

Black nurses were aware of their colleagues' preferences, and thus they were keenly attuned to how their organization's institutionalized practices disadvantage black nurses in the hiring process. This is evident, for example, in the ways black nurses like Yasmin suspect colleagues of devaluing applicants with degrees from HBCUs. As with predominantly white institutions (PWIs), there is a hierarchy among HBCUs, with some (Spelman, Morehouse, Hampton) considered higher status than others (Bowie State, Coppin State, Morris Brown). Although black nurses now have more access to nursing schools, organizational preferences for graduates from PWIs can adversely affect their job searches. Furthermore, nurses who not only attend HBCUs but graduate from the less visible, lower-status ones may find themselves especially disadvantaged.

Black technicians had additional layers between themselves and hiring managers. They were rarely if ever consulted about potential candidates, and unlike doctors, they were never a part of the hiring process. As such, they did not offer an insider's knowledge of how the hiring process perpetuates racial discrimination, and they did not cite this as an example of organizational racial discrimination that affected them. This is not to say technicians escaped discrimination in the hiring process; as noted earlier, Mona described facing discrimination from a hiring manager. But it is important to note that Mona cast this as an example of this manager's personal preference (and thus a case of individual discrimination) rather than a problem stemming from organizational processes. We argue that this perception comes from one's position in the organizational structure and the extent to which differently situated workers are exposed to the ways hiring functions as a means of maintaining racial disparities.

In addition to hiring, this mechanism may matter in other ways for black workers who are highly placed in the organizational hierarchy. Inasmuch as professional development for those at the top relies on social networks (e.g., mentoring), black workers high in the organizational structure note that they have few black workers to whom they can turn. Networking is a key component of career advancement, particularly for professional workers (Gershon 2013). This could explain why the absence of black mentors stood out to black doctors as a noteworthy obstacle, whereas black nurses and technicians rarely mentioned a shortage of black mentors as an example of the effects of discrimination.

Impact of positional status on exposure to others. Certain doctors may engage in more collaborative projects (e.g., surgical teams), but in many cases doctors' position at the top of the organizational hierarchy meant they more frequently worked alone, compared to nurses or technicians who spend most of their time interacting with patients and colleagues (Butler et al. 2018). For black

doctors, the lack of social interactions with others limits their opportunity to experience individual discrimination. Field observations of doctors in the workplace revealed that they spent much of their time seeing patients only after nurses did most of the preliminary work with patients. One pediatrician in a private practice who allowed the first author to observe her at work agreed that the autonomous design of how many doctors work minimizes interactions that could potentially include individual discrimination. Field notes revealed that on most days, once this doctor exchanged brief hellos with other doctors in the practice, she had no communication with other physicians and had no interactions with nurses that lasted longer than five minutes.

Working in jobs lower in the organizational hierarchy, black nurses and technicians inhabit a position where interaction with colleagues and patients is both more common and subject to greater supervision. This routinization, and particularly the fact that black nurses and technicians were subject to more supervision than doctors, created a dynamic where black nurses and black technicians simply had more interactions and thus more opportunities to observe individual discrimination. Inasmuch as these interactions included overtly racialized stereotypes of laziness and unprofessionalism, black nurses and technicians easily characterized these interactions as cases of individual bias. Positional status in the organization heavily influences the extent of black employees' exposure to others, and it gives black doctors fewer interactions where they might perceive individual discrimination.

Our data do not allow us to measure "actual" cases of discrimination; thus, it may be that doctors encounter more cases of individual discrimination than they realize. However, our interviews show a clear pattern of doctors reporting that they observed very few cases of individual discrimination as part of their work, particularly relative to black nurses and technicians. Whether or not doctors actually faced more individual discrimination than they were aware of, our argument is that the

difference in perception can be explained, in part, by how positional status decreases exposure and leaves doctors with fewer encounters that could give rise to interactions they might describe as discriminatory.

Emergency medicine doctors' more frequent observations of individual discrimination support our arguments. Recall that these doctors were more likely than physicians in other specialty areas to describe individual discrimination from white patients. Due to the nature of their work, emergency medicine doctors may have less control over the type and extent of their exposure to patients than do other physicians—they must treat whoever comes into the ER, and they face a wider range of patients than do doctors in other specialty areas.

Our findings suggest there may be some organizational variation in the extent to which positional status limits exposure to others. When it came to perceptions of discrimination from colleagues, we found little organizational variation. However, when recounting perceptions of discrimination from patients, organizational variation did emerge. Black healthcare workers (doctors, nurses, and technicians) who shared accounts of individual discrimination noted that these incidents came from white patients who refused treatment, challenged their authority, or undermined them. We expect black healthcare workers employed in facilities that infrequently treat white patients might perceive fewer instances of these forms of individual discrimination. Thus, while we argue that position in the organizational hierarchy informs how black workers observe discrimination, our data show that variation between organizations can enhance or minimize workers' exposure to interactions where discrimination may be perceived.

Use of status and power in interactions. Social psychologists have long demonstrated that relative status shapes social interactions such that higher-status individuals are provided more deference and respect than individuals with relatively lower status (Ridgeway 2011). We argue that in the workplace, perceptions of individual discrimination

depend, at least in part, on relative status during social interactions (Stainback, Ratliff, and Roscigno 2011; for supervisory bullying in general, see Roscigno, Lopez, and Hodson 2009). During interactions, lower-status individuals are constrained in their ability to question or criticize higher-status colleagues, are more likely to be deferential, and thus have less opportunity to discriminate; higher-status individuals are relatively less constrained in their ability to question lower-status individuals, are less deferential, and have more opportunities to discriminate or to act in ways that can be perceived as discriminatory (Correll and Ridgeway 2003).

Black doctors' higher status in the organizational hierarchy could mean that, relative to black nurses and technicians, they may have fewer interactions that could give rise to individual discrimination. These doctors may also have more ability to set the tone for how their interactions with nurses and technicians proceed. Research on black professionals shows that they carefully wield status symbols in an attempt to deflect and offset potential racial slights (Lacy 2007; Wingfield 2012). The ability to control interactions (to some degree) could mean black doctors have more opportunities to minimize exchanges that could lead to individual discrimination.

Nurses and technicians, by virtue of their lower position in the organizational setting, have fewer opportunities to structure interactions in ways that could command deference and possibly offset individual discrimination. Technicians, who are at the bottom of the organizational structure relative to nurses and doctors, may find few opportunities to set the tone for their interactions with nurses. Consequently, these interactions may be more likely to be sites of interpersonal racial discrimination.

Gender differences among black doctors, nurses, and technicians. Overall, our findings show that position in the organizational structure affects perceptions of discrimination, and this holds true for black men and black women in all three professions. However, doctors and nurses work in

gendered occupations, with high levels of sex segregation and gendered assumptions about the expectations, workers, and labor associated with these jobs (Acker 1990). Black doctors and black nurses cited similar perceptions of discrimination, but the gendered occupations in which they were employed were also a factor. Physicians can be characterized as doing "men's work," with respondents like Caroline describing it as an "old boys' club" where men benefit from tacit assumptions that they inherently possess the rigor, intelligence, and skill the job requires. The low numbers of women of all races in the profession could help explain why black women doctors see mentoring relationships as a structural impediment to their advancement. Finding mentors is somewhat easier for black men in white male-dominated professions than for women of all races; thus, although both black men and women doctors noted the difficulty in finding black mentors, this particular challenge may seem more apparent to black women (Turco 2010; Wingfield 2012).

When it comes to nursing, different gendered dynamics may be at play. Nursing can be considered "women's work" due to both the gender composition of the profession and the associated expectations of patient care, deference, and support (Trotter 2020; Williams 1995). Acker (2006) summarizes decades of research finding that jobs composed predominantly of women tend to fall lower in the organizational hierarchy, offer lower pay, and include more ambiguous job descriptions. Recall that many black nurses cited examples of individual discrimination from supervisors at moments where there was confusion or uncertainty about who should be performing certain tasks. For black nurses, working in a feminized occupation may have created conditions (e.g., a lack of clarity around responsibilities) that made them more attuned to individual discrimination.

Technicians' work, although predominated by women, is not as overtly gender-typed as medicine and nursing. In the absence of widespread, culturally defined representations of technician jobs as "women's" or "men's" work, the individual discrimination technicians

generally describe is itself gendered. Note that Mona referenced individual discrimination from a potential employer who carefully scrutinized her physical appearance, dress, and body size—an experience common for black women in professional settings (Bell and Nkomo 2003). Marcus, in contrast, described individual discrimination from patients' families who appeared uncomfortable with him providing treatment—an issue many black professional men face (Wingfield 2009, 2012). Technicians' work is not explicitly gendered, but black workers may perceive discrimination at the individual level as gendered.

DISCUSSION

We return now to the original questions framing this article: What accounts for the variations in how black workers perceive racial discrimination? Why do some workers consider discrimination embedded in laws and institutions to be more pervasive and salient, whereas others focus on discrimination from individuals? Why might more educated black workers emphasize racial discrimination that is built into social structures and institutions?

Our findings suggest that position in the organizational hierarchy presents an important, although overlooked, piece of this puzzle. Black workers at the top of the organizational hierarchy have a perspective on discrimination that spans multiple organizations and fields, thus making them attuned to the ways discrimination can be institutionalized within and across social structures. Black workers who are lower in the organizational hierarchy certainly face organizational discrimination as well, but they are more likely to see this as a function of individual preferences and choices and less likely to have access to the decision-making processes that would reveal these more structural sources of discrimination.

Our findings support theories of racialized organizations, but we extend these theories further by identifying mechanisms that connect position in the organizational hierarchy to perceptions of racial discrimination: attainment of the position, navigation of

organizational levers of power, impact of positional status on exposure to others, and use of status and power in interactions. We develop these theories by showing that organizational variation can matter—certain types of racialized organizations (i.e., those that primarily serve populations of color) may mitigate against black employees' impressions of individual racial discrimination. By recognizing the importance of organizations in the distribution of resources, we emphasize how black workers' relationship to the organizational structure helps explain how they perceive racial discrimination as a phenomenon that affects their everyday work lives.

Sociologists have come a long way in understanding how race and racism are embedded in the structures of U.S. society (Bonilla-Silva 2001, 2018; Elias and Feagin 2012; Omi and Winant 2014). Yet despite the extensive research documenting that discrimination persists, little empirical study is devoted to understanding how black individuals perceive the discrimination they face or how to explain the variations in their assessments. This omission has resulted in overly general conclusions regarding how black people (and other minorities) perceive racism—they perceive more discrimination (broadly defined) than whites (Pew 2016), are less likely to believe racial disparities result from individual failings (Bonilla-Silva 2001), and their social class shapes some differences in how much discrimination they perceive (Anderson 1999; Lacy 2007). Theorists are now beginning to recognize that organizations are important meso-level, racialized structures that play a fundamental role in distributing social and economic resources unequally along racial lines (Acker 2006; Ray 2019). This article thus builds on previous studies that primarily focus on how racial minority status informs black workers' accounts of individualized examples of workplace discrimination, and we identify how position in the organizational structure is a major determinant of the level and nature of racial discrimination that black workers perceive.

Exposure to Different Types of Discrimination

The mechanisms we identify in our case study highlight two overarching themes to describe how position in the organizational structure relates to perceptions of discrimination at work. First, position in the organizational hierarchy limits or expands the opportunities for black workers to be exposed to different types of discrimination. Following a structural opportunity perspective (Petersen and Saporta 2004), due to their experiences acquiring the necessary qualifications across overlapping educational and work organizations, black healthcare workers in higher-status positions in the organizational hierarchy are more likely to be exposed to structural discrimination than are workers in lower-status positions. They have more opportunity to witness organizational discrimination as enactors of institutionalized rules and norms that disadvantage minorities within the firm, and through their experience with professional development norms that expose the disadvantages of lacking same-race peers. Relatedly, black healthcare workers higher in the organizational hierarchy have more autonomy in the workplace, which limits (and allows them to limit) their social interactions, reducing their exposure to individual discrimination. Black workers lower in the organizational hierarchy are more likely to be supervised, and thus they have more opportunity to experience individual discrimination during evaluation or reprimanding interactions. In short, place in the organizational hierarchy shapes black workers' personal, explicit, and repeated exposure to individual, organizational, and structural discrimination.

Altering Perceptions of Discrimination

The second overarching theme is that position in the organizational hierarchy influences how black workers perceive potentially racialized events. Black doctors, and to a

lesser extent black nurses, learn to recognize organizational and structural discrimination given their lived experience in attaining the credentials for their position, their personal experiences going through the hiring process, their socialization in higher education to become sensitive to organizational and structural discrimination when it occurs, and their participation in organizational discrimination as employees. Thus, a black technician like Mona who faces heightened scrutiny during the hiring process might view the event as individual discrimination due to the supervisor's personal prejudice; a black nurse like Yasmin, however, with intimate knowledge of similar and repeated incidents, might attribute this scrutiny to organizational discrimination inherent in a racialized credentialing process.

Status dynamics during social interactions likely influence perceptions of individual discrimination. Given racial segregation and concentration of minorities at the bottom of the organizational hierarchy, black workers are more often in social interactions in which they have relatively lower status, are treated with less respect and deference, and experience more criticism, evaluation, and reprimand from superiors who are often white (Ray 2019). Under such conditions, black workers are likely to perceive repeated negative and abusive social interactions as mounting evidence of individual racial discrimination rather than as isolated, ambiguous instances that are easily brushed off.

In summary, position in the organizational hierarchy shapes black workers' perceptions of racial discrimination by altering their exposure to and perception of different types of racial discrimination. As organizations mediate racial inequalities, so too do black workers' interactions with organizational structures mediate their perceptions of individual, organizational, and structural discrimination.

Opportunities for Future Research

Given our case study design, future research will need to refine and expand on our initial offerings regarding the relationship between organizational structure and black workers' perception of discrimination. First, while we identify a number of mechanisms connecting position in an organization to perceptions of racial discrimination, it would be useful to consider other patterns of organizational variation. The hospital facilities in which our respondents worked are extreme versions of organizational hierarchies in which there are large and defined differences in status and function for doctors, nurses, and technicians (Diefenbach and Sillince 2011). The relative importance of the mechanisms we highlight may differ in organizations with "flatter" hierarchies in which there are fewer status distinctions and less clarity as to how to achieve promotion to a higher level (Ridgeway 2009). We also do not differentiate our respondents by the "diversity"-related policies or practices of their work organizations, and indeed, the presence of such institutionalized policies may lessen the importance of some of the mechanisms described. For instance, if an organization has implemented strong and effective practices for recruiting and retaining workers of color, exposure to organizational hiring practices could be a less important mechanism for perceiving organizational discrimination than we found here. Finally, medical facilities are racialized organizations that can disadvantage their black employees. Thus, the theoretical relationship between organizational structure and perceptions of discrimination may be fundamentally different in organizations that evenly distribute resources by race (or that advantage blacks), if such organizations exist.

Second, medical institutions are not only racialized organizations but highly gendered ones, in which women are underrepresented among physicians and vastly overrepresented among nurses. It is worth considering whether employees in different kinds of gendered organizations—that is, organizations that do not provide such clear and consistent advantages to men—might yield different outcomes. Future research should explore this possibility. Finally, our analysis is limited to

exploring perceived racial discrimination among black healthcare workers. Additional studies can and should explore how position in the hierarchical structure influences white workers' perceptions of discrimination, particularly whether personal exposure to the norms and practices that produce racial inequality also heighten white workers' perceptions of organizational discrimination.

Third, we limit our analysis to black workers, but our theoretical framework for perceived discrimination might extend to other ethnic and racial groups. For instance, given the similar distribution of black and Latino workers among doctors, nurses, and technicians, Latino employees' perceptions of workplace discrimination may follow a similar pattern.[6] Asians are far better represented among physicians than either blacks or Latinos (22.0 percent compared to 5.5 and 6.4 percent, respectively), and it is an open question as to the extent and nature of perceived discrimination for this group. Future research should also determine the extent to which position in an organizational structure influences perceived discrimination only toward one's own racial group, or whether it influences perceptions of racism in general.

Implications for Inequality Research and Organizational Policy

This study has important implications for understanding the role of racialized organizations in how black and white workers perceive racial discrimination today. As previous scholars suggest (Acker 2006; Ray 2019), and our findings reinforce, work organizations are instrumental in producing racial inequalities that are, in general, "bad" for black people (and minorities) as a *group*: black workers are often segregated at the bottom of the organization hierarchy, and as a result, they not only receive fewer social and economic rewards, but they are more exposed to individual discrimination from others they encounter on the job. However, such racialized organizations may paradoxically be "good," to some degree, for black *individuals* who make it to the upper levels of the organizational hierarchy. To be sure, such individuals perceive more structural discrimination, but they also perceive far less individual discrimination in their work lives and benefit far more economically.

As work becomes ever more important and all-consuming in our lives, work organizations themselves may be a major reason for the divergence in perceptions of race, racism, and even political affiliation within the black community—divergences which heretofore have been associated only with social class. Lacy (2007), for instance, shows that middle-class blacks can and do use class positionality to deflect racial slights at work and in public settings. Our findings suggest it is perhaps more one's position at work that makes such incidents seem so infrequent and easily brushed off; black workers lower in the organizational structure may find more routinized individual discrimination harder to avoid and dismiss. Work organizations may also help explain why white individuals—who are more likely to work in higher levels of the organizational hierarchy—perceive race to be unimportant in affecting people's life chances (Pew 2016). From their perspective, *individual* black workers (and other people of color) have attained similar levels of status and success at work, making them blind to the collective effects of structural racial discrimination.

Our findings also have implications for documented health consequences of perceived racism. Previous research suggests that for black workers, perceptions of racial discrimination at work have real health consequences, such as increasing levels of stress and hypertension (Cose 1993; Lee and Turney 2012; Pavalko et al. 2003). Our empirical finding that disaggregates perceived discrimination into individual, organizational, and structural dimensions calls into question whether health consequences depend on the type of racism black workers perceive. Racialized health outcomes among black Americans may not necessarily be driven by exposure to overt, interpersonal forms of racial hostility, but rather by enhanced perceptions of and

experience with organizational and structural discrimination, or the type of health consequences may depend on the type of discrimination perceived. Our findings provide a framework to help researchers understand how variations in perceived discrimination relate to health consequences, and to help them tailor interventions accordingly.

Finally, our work can inform organizational policies designed to make the workplace hospitable and welcoming for diverse constituencies. Now that many companies are attempting to wrestle with issues of diversity and inclusion, organizations are more attuned to the ways they may be underserving black workers and looking for ways to create more equitable environments. A common criticism of such corporate programs is that they do not help those who are most affected by hostile workplaces but instead either help those already in higher-status jobs (Berrey 2015) or are completely ineffective (Ferguson 2015). By providing insight into which workers perceive the most individual racism, and under what circumstances, our research may help organizations tailor their policies toward those most in need.

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ORCID iDs

Adia Harvey Wingfield https://orcid.org/0000-0003 -1532-6989
Koji Chavez https://orcid.org/0000-0002-9183-2122

Notes

1. We refer here to "structural" racism rather than "systemic" racism to avoid confusion with Feagin's (2006) book with this title. Feagin (2006), Bonilla-Silva (2001, 2018), and Omi and Winant (2014) all emphasize the systemic processes that reproduce racial inequality, but there are important differences between these theoretical paradigms, which we outline. Given these differences, we do not want to conflate Omi and Winant's (2014) or Bonilla-Silva's (2001, 2018) theories with Feagin's (2006) specific theory of systemic racism. Thus, we use "structural racism" to refer to theoretical approaches that highlight ways multiple, interconnected social institutions (e.g., educational, legal, political systems) institutionalize and maintain racial hierarchies and inequalities.

2. See https://www.healthaffairs.org/do/10.1377/hbl og20180502.984593/full/ (accessed June 29 2019).

3. Even when the occupational categories suggest workers are represented at parity, the heterogeneity associated with these occupations means black workers are still likely to be employed in predominantly white spaces. Thus, although black technicians are technically at parity with their population in the United States, technicians in this study were still employed in "racialized organizations" where they were in the racial minority.

4. See https://datausa.io/profile/soc/physicians-surg eons (accessed June 29, 2019).

5. "Cultural competency" refers to an increasingly common trend in both medicine and nursing where practitioners are urged to become more familiar with how cultural background may influence patient behavior.

6. Latinos represent 6.4 percent of physicians, 7.2 percent of nurses, and 11.5 percent of technicians; blacks represent 5.5 percent of physicians, 13.9 percent of nurses, and 13.4 percent of technicians (American Community Survey 2017 five-year sample from the Integrated Public Use Microdata Series [Ruggles 2019], author's calculations).

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Adia Harvey Wingfield is the Mary Tileston Hemenway Professor in Arts & Sciences and Associate Dean for Faculty Development at Washington University in St. Louis. She is the author of multiple books and articles, most recently *Flatlining: Race, Work, and Health Care in the New Economy*. Professor Wingfield frequently writes for mainstream outlets including *The Atlantic, Vox*, and *Slate*. She is the winner of the 2018 Public Understanding of Sociology Award from the American Sociological Association, a former President of Sociologists for Women in Society, and the President-elect of the Southern Sociological Society.

Koji Chavez's current research focuses on inequality-producing social processes within organizations. His research highlights how gender, race, ethnicity, and "foreignness" influence perceptions and experiences at work, including how decision-makers evaluate job candidates and legitimate hiring decisions.