# FIVE “Doctors Don’t Know Anything”

## THE CLINICAL GAZE IN MIGRANT HEALTH

When I first arrived in San Miguel, I attempted to explain to the officials at *la presidencia* (the town hall) my reasons for being there. I said that I was hoping to live in town for several months to learn about the everyday life and health of the residents. The official in charge of legal issues *(el síndico)* explained that there was nowhere to stay, no hotel or guest house, but that I could work in the Centro de Salud (government clinic) in town since it was short-staffed. San Miguel has a small, federally funded clinic staffed alternately by a medical resident *(pasante)* and a nurse, often with a day or two in between when there is no staff. Every medical resident in Mexico is required to spend the year after graduating from medical school doing community service and is assigned a clinic. A new medical resident comes to the clinic each year, and most of the nurses are rotated by the federal government at least once a year. Thus there is minimal rapport between the village and the clinic staff. The síndico told me that the nurse, Josefina, and the doctor, Juan, were both from Oaxaca City and spoke only Spanish.

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The village of San Miguel, Oaxaca. Photo by Seth M. Holmes.

The síndico's suggestion that I help in the Centro de Salud made me nervous; I was concerned that I might be pigeonholed as only a medical practitioner instead of an anthropologist and that I might be mistaken for a fully trained physician. I told him that I would be interested in observing the physician and nurse in town and assisting when appropriate but that I was there primarily to learn from the people and that I could not practice medicine on my own. He looked disappointed and confused. When I repeated that I was there primarily to observe and learn from the Triqui people about their lives and health, he still seemed unconvinced that I could not fill a position at the clinic. I tried to explain that I had not finished my training as a physician and still needed to be supervised by a doctor with more experience. The síndico replied, "Ese médico no sabe nada" (That doctor doesn't know anything).

This harsh statement took me aback. I wondered whether it was due to a difference in illness explanatory models between an indigenous Triqui person and an urban allopathic physician, an appropriate judgment of the lack of knowledge of a pasante not yet finished with his training, or the result of a lack of knowledge or bedside manner on the part of this particular médico. I assumed, irrespective of the primary reason, that the account was specific to Juan and the situation in the Centro in San Miguel.

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However, as I continued my fieldwork in Washington, California, and Arizona and returned to San Miguel during the tenure of a new pasante, I heard “Los médicos no saben nada” (Doctors don’t know anything) in several contexts. I found this refrain quite disconcerting. I had assumed that the physicians working with the Triqui people in migrant clinics or government-funded clinics in Oaxaca would be appreciated, partly because they had forgone prestige, state-of-the-art facilities, and higher salaries in order to work with this population. In addition, I was in the midst of demanding training to become not only an anthropologist but also a physician, and I wanted to work in the future in both capacities with Latin American migrant laborers. Why did the Triqui people think that the physicians working with them did not know anything? What was wrong with the doctor-patient relationship? Why was it so unhelpful in its present form? Could it be changed to be more helpful for my Triqui companions? What were the economic, social, and symbolic structures impeding such change? And how might anthropology speak to clinical medicine and public health? These questions form the impetus for this chapter.

In the previous chapter, I described the illness narratives of Abelino, Crescencio, and Bernardo, considering the effects of the different expressions of violence at work in migrant farm labor. Here I continue the histories of Abelino’s knee, Crescencio’s headache, and Bernardo’s stomach pain as these individuals interact as patients with health professionals in Washington, California, and Oaxaca. Using these illness narratives as well as interviews with clinicians and observations of clinical encounters, this chapter explores both the structural factors affecting migrant health care and the lenses through which health professionals perceive their migrant patients.

## THE CLINICAL GAZE

As an anthropologist and a physician, I am concerned both with theorizing social categories and their relationships with bodies and with the possibility that suffering might be alleviated in a more respectful, egalitarian, and effective manner. My dual training has been at once stimulating and disorienting. The lenses through which cultural anthropologists and physicians are trained to see the world are significantly different, and at times contradictory. I have found the critical social analyses of anthropology incredibly important at the same time that I have valued the grounded human concerns of clinical medicine. Others at the margins of clinical medicine and anthropological analysis have offered valuable insights and methodologies. Well known are Kleinman’s writings

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on illness narratives and the explanatory models of patients as well as Farmer's essays on pragmatic solidarity and structural violence.[1] Kleinman's work focuses on the ways patients somatize social realities and on the importance of clinicians listening to their patient's understandings of illness. Farmer's work drives home the importance of structural determinants of sickness and calls for more equal distribution of biomedical resources.[2] This chapter takes the analyses of Kleinman on the perceptions and explanatory models of patients and of Farmer on the effects of structural violence on patients and turns them on their heads by focusing on the health professionals rather than the patients. After accompanying my Triqui friends to migrant clinics, hospitals, and traditional healers in the United States and Mexico, I have become interested also in the ways in which social and economic structures affect health professionals, the lenses through which they perceive and respond to their patients, and the care they are ultimately able to offer.

One of the most important analyses of the perceptions of medical professionals in the clinical encounter is Michel Foucault's *The Birth of the Clinic*.[3] Foucault describes what he calls "the gaze." He explains that the clinical encounter changed drastically from the eighteenth to the nineteenth century: "This new structure is indicated . . . by the minute but decisive change, whereby the question: 'What is the matter with you?', with which the eighteenth-century dialogue between doctor and patient began . . ., was replaced by that other question: 'Where does it hurt?', in which we recognize the operation of the clinic and the principle of its entire discourse."[4]

Around the time of the advent of the dissection of cadavers, the conception of disease transformed from an entity affecting the whole person to an anatomically localized lesion. It was no longer considered necessary for doctors to listen to patients describe their experience of the illness—their symptoms—in order to diagnose and treat. Instead, physicians began to focus on the isolated, diseased organs, treating the patient increasingly as a body, a series of anatomical objects, and ignoring the social and personal realities of the patient, the person. In the paradigm of the clinical gaze, physicians examine and talk about the patient's diseases, while the patient remains largely silent. In many ways, this can be seen as the advent of modern positivist science in which human, social, and historical contexts are considered irrelevant.

Since the change described by Foucault, many medical scholars have critiqued clinical medicine's objectification of patients. The aphorism, "Ask not what disease the patient has; ask what patient has the disease," has been attributed to the nineteenth-century Canadian physician Sir William

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Osler.[5] In the mid-1990s, Tom Boyce, a pediatrician and sociobiologist, wrote similarly, "For me, there is a growing unease that, in our headlong efforts to bring into focus finer and more discriminating views of the lesions lying *beneath* disease, we will have missed the opportunity to envision the person or the patient that lies *beyond* the disease."[6] Boyce describes the clinical gaze as the "myopic vision" that sees through the patient to focus on the pathology, the organ, the lesion.

Others discuss the consequences of the paradigm of the gaze for health professionals themselves. Stefan Hirschauer describes the ways surgery transforms everyone involved—patient, surgeon, nurse—into tools.[7] The rituals surrounding surgery depersonalize not only the patient but also the health professionals. Yet he implies that this temporary, ritualistic depersonalization protects the personhood of everyone involved. Similarly, Joseph Lella and Dorothy Pawluch describe the dehumanizing experience of medical students in the objectification of cadavers.[8] As the students objectify the human bodies they dissect, they experience their own dehumanization.

The clinical gaze is taught not only in the anatomy lab and the operating room but also in the models of doctoring presented to students. Holmes and Maya Ponte, both anthropologists and physicians, explain that the structure of the written and verbal medical student patient presentation transforms patients and their human, social, and bodily reality into generalized cases of a medical disease at the same time that it protects the students from uncertainty.[9] Melvin Konner, an anthropologist and physician, writes of his experiences as a medical student in *Becoming a Doctor.*[10] For the most part, he writes, resident and attending physicians model survival skills and patient objectification instead of an interpersonal relationship with the patient. In the conclusion, Konner specifies that the doctor-patient relationship is not one of "I-Thou," as Martin Buber would have it, but rather one of "We-You."[11] This is meant to show the primacy of interactions among physicians and trainees; they form a medical team, a "Doctor-Doctor" relationship. Only after the team exists as a relational entity is there a relationship with the patient. This can be seen also in Foucault's description of Charcot and the Salpêtrière Clinic.[12] Charcot displayed female patients in front of psychiatry trainees in order to teach about hysteria. He spoke about the patients, had them touched and prodded (including their pubic areas), and had them taken away if their poses became too sexual. In this way, the Doctor-Doctor relationship of Charcot and his trainees led to the objectification of the women such that they were hidden if they showed too recognizable a sign of their

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personhood.

More recently, Beverly Ann Davenport has analyzed one of the homeless clinics that have become a notable part of the training of medical students. This is a space of struggle between two medical paradigms, "witnessing" and the medical gaze.[13] Witnessing, or treating patients as whole persons, Davenport writes, is taught by physician-educators in this clinic as conscious resistance to the medical gaze. Physicians attempt to enact this humanizing model, all the while practicing within a system characterized by the biotechnical. At some points they model witnessing to their students, while at others they enact a myopic gaze on pathology.

I am especially interested here in discovering how the analyses of the medical gaze by Foucault and others apply to the field of migrant health in the twenty-first century. What are the characteristics of the medical gaze in a contemporary migrant clinic? How do they relate to the relatively recent movement to make medical education "biopsychosocial" and culturally competent? How do they relate to larger social, economic, and political structures? What might be an alternative model for the migrant clinic? I explore these questions through the interactions of Abelino, Crescencio, and Bernardo with the health care system.

## ABELINO'S KNEE: STRUCTURE AND GAZE IN MIGRANT HEALTH CARE

Two days after Abelino's knee accident, the crop manager canceled picking in the morning because of a heavy, cold downpour. Abelino and I went to an urgent care clinic. Abelino ended up seeing several doctors and a physical therapist over the next several months, usually without a Spanish translator and never a translator proficient in Triqui. During these months, he limped around camp, taking care of his kids while his wife and eldest daughter continued to pick in the fields.

The urgent care doctor listened briefly to Abelino's description of what happened and examined his swollen right knee. He ordered an X-ray, which showed that no bones had broken but could not show anything of the soft tissue, tendons, bursa, meniscuses. The report from the X-ray concluded, rather simplistically, "normal right knee." The doctor explained that Abelino should not work picking berries, emphasizing rest to let his knee recover. This physician was not sure if the knee pain was due to a ligament sprain or a meniscus tear and planned for further evaluation once the pain had subsided. Abelino asked for an injection, a common method of medication administration in Mexico, and the doctor refused. Instead, he gave Abelino a referral to physical therapy, an anti-inflammatory medicine,

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and instructions on icing his knee regularly. This urgent care physician also filled out the paperwork to open a worker's compensation claim for Abelino with the State of Washington Department of Labor and Industries (LNI). Two days later, Abelino went in to see the physical therapist, who performed his own evaluation of the knee. At this point, Abelino described his knee pain as a 7 on a scale with 10 being the worst pain imaginable. The physical therapist gave Abelino knee exercises to do at home and recommended a consultation with an orthopedic specialist.

The next week, when Abelino and I went to the clinic for his appointment, the original urgent care doctor was not on duty, so we saw one of his partners. This physician looked at Abelino's chart, listened briefly to Abelino tell him what had happened, and told Abelino that he could work "light duty," provided he did not bend, walk, or stand for long periods. This doctor filled out a form to this effect and gave it to Abelino to take to the Tanaka farm. The doctor explained the cause of injury in the chart as "while picking, twisted his right knee." This description is not only vague; it also linguistically makes Abelino the subject whose action produced the problem: *he* twisted the direct object, his knee. Although Abelino has chronic gastritis such that he cannot eat traditional spicy Triqui food and although the physician did not ask Abelino about any stomach symptoms, this physician wrote in the chart, "[Patient] also specifically states he has no GI upset from taking NSAID." Nonsteroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen, aggravate gastritis, and there is a relative contraindication to their use in the context of gastrointestinal problems. No future health professional working with Abelino double checked this assertion. The physician gave Abelino a brace and instructed him to wear it. Abelino later told me that the brace made the pain worse, so he wore it twice only. That afternoon, Abelino went to the farm office to ask for lighter work. The bilingual receptionist, Samantha, told him in a frustrated tone, "No, because no *[No, porque no],*" and did not let him talk with anyone else.

In the meantime, Abelino consulted a Triqui healer. This elderly monolingual man who worked during the day picking strawberries saw Abelino at night in his labor camp shack. I sat in on the consultation, and Abelino translated the words I could not understand. The healer shuffled and rearranged a deck of Mexican cards several times in order to understand the source of the pain. He let Abelino know that the spirit of a person Abelino had seen die had attached to him. In order to get rid of the spirit and heal his patient, the Triqui healer covered several raw eggs in rum and rubbed them over Abelino's body, especially around his knee. The rum-covered eggs might be able to entice the spirit to attach to them

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instead, he explained. Next, he left the shack and threw the eggs into the distance, luring the spirit away from Abelino's knee.

Over the next few weeks, as Abelino rested, his knee pain subsided somewhat, to 5 out of 10 on the pain scale. He was able to walk with a limp, but it still brought excruciating pain if he tried to bend or squat. Since Abelino was not given the option of lighter work, he attempted to return to picking strawberries to help support his family. The swelling immediately increased, and the intense pain returned, so Abelino stopped working again after two days.

Nineteen days after the injury, LNI opened a claim for Abelino that would pay his medical bills and two-thirds of his salary while he was unable to work. The medical and worker's compensation coverage would end when Abelino's knee had improved enough for him to go back to his job or the problem was deemed chronic without improvement. The LNI file states that he returned to work on "lite duty until reinjured knee." It is unclear how LNI understood Abelino's return to strawberry picking as "lite duty." The urgent care physician recognized this was an incorrect representation and wrote in the medical chart that there was "apparently no light duty work" at the Tanaka farm, without checking this assertion. The LNI file also states, "He indicated he does not speak English. I asked him if he speak Spanish, he said yes (I think)." However, LNI did not order or authorize a Spanish interpreter for his medical appointments for another two weeks. Three months after this note, LNI put an alert in Abelino's file that all communication should be sent to Abelino in Spanish. The vast majority of letters that were sent after that time, however, were in English only.

The Tanaka farm told LNI that Abelino made $7.16 an hour and that he did not receive any other benefits. This report undervalued Abelino's pay considerably since he routinely picked well above the minimum and received housing as part of his benefits. The farm sent a copy of Abelino's working hours and pay for the month *beginning* with his knee injury, a month in which he worked only two days and picked very slowly. This incorrect information was used by LNI to calculate how much Abelino worked *before* his injury and, therefore, his benefits. A pro bono social worker from a local nonprofit phoned LNI to find out what was needed and helped Abelino fax copies of his checks from the month prior to his injury to rectify the hours, though LNI never recalculated Abelino's benefits. LNI sent Abelino a letter written in English two months after the injury and one month after they calculated his worker's compensation, asking him to review their calculations and let them know if he received housing or any other benefits. Unable to read the letter, Abelino did not respond. Once I

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saw the letter, I called LNI to request that his wage be recalculated to include his housing. This request was entered into his file and never acted on.

The urgent care doctor requested an orthopedic consult, which reaffirmed the recommendation of light duty work. He also ordered an MRI scan, which showed normal bone structure with abnormal swelling in the soft tissues in front of, below, and internal to the patellar tendon. The MRI report concluded that there was “no instability” in the knee, though it did not specify what precisely this meant. After a few weeks of seeing Abelino without significant improvement, the urgent care doctor ordered the physical therapy discontinued and successfully passed his patient off to a rehabilitation medicine specialist.

The rehabilitation medicine physician initially did not want to take on an LNI patient because of the extra paperwork involved but eventually agreed. This physician restarted Abelino’s physical therapy since it seemed to help and told Abelino that he must work hard picking strawberries in order to make his knee better. She did not seem to be aware that his attempt to return to work had caused more pain and swelling. In addition, she seemed to think his last name was his first name and repeatedly addressed him in this way. She asked me to translate that he had been “picking incorrectly and hurt his knee because he did not know how to bend over,” though in the midst of her busy schedule she had not asked how he picked or bent over. She wrote in her chart, which was riddled with typos, that “he is a somewhat poor historian, however, secondary to the language,” though it could have been equally true to say she was a poor interviewer due to language barriers. Nonetheless, she did not request a translator for Abelino’s future appointments. She concluded the appointment, handing him a prescription for strong NSAIDs. Like the previous physicians, she did not ask Abelino if he had contraindicating stomach problems.

After a few months, LNI arranged a meeting for Abelino with administrators from the Tanaka farm and a consultant to determine what kind of work agreement might be reached. Abelino and I went to the farm’s front office for the meeting. When Samantha came into the room twenty minutes late, she greeted us warmly. The other farm official was still meeting with the LNI consultant in another room and called to say that they were running late. Samantha replied, “No problem, take your time.” I wondered why the consultant was meeting with the farm administrators without Abelino. Samantha turned to Abelino and said in Spanish that it was cold outside. Abelino replied that it was really cold in the labor camps. I explained that the morning frost on the inside of the tin roofs melted

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every morning as a cold indoor rain on the inhabitant's face and belongings as soon as the sun rose. I also mentioned that most of the families in our camp had to leave their gas stoves on all night to keep the inside from freezing. Samantha said in Spanish, "Yeah, yeah, it's so cold! I live on a *ranchito,* and I have two geese and four cats and two horses and two dogs. And every morning the water for the horses is frozen and I have to go out in my slippers with hot water and give water to the horses and the other animals and when I come back in it's so cold it's hard to use my hands!" I remember feeling surprised and offended that Samantha seemed unaware of the fact that hundreds of people on the farm lived and slept without insulation or heat in the below-freezing temperatures while she complained about her hands getting cold temporarily in the morning. Abelino responded, "Oh, so you have a rancho?" Samantha, "No, no, it's just a couple acres—it's a ranchito." Much like the "contest of suffering" in California's Proposition 187, described by James Quesada,[14] Samantha diminished the ongoing suffering of the Triqui migrants by giving precedence to her own temporary suffering.

Once the LNI consultant and the Tanaka farm administrator arrived, the consultant explained to Abelino, with Samantha translating, that she would help him get light duty work on the farm. Abelino explained that he needed to move to California with his family a month later, when the picking season in Washington ended. He told her that what he really wanted was for the farm to guarantee him a light duty job for the next season the following summer. The consultant explained that if Abelino left the state of Washington, LNI would no longer cover his medical bills related to the work injury and would no longer help him get light duty work. He restated his request for light duty work for the next season; she restated that his file would be closed if he left the state. The farm official sat silent, the meeting ended, and everyone shook hands.

Soon thereafter, the LNI consultant filed a form recommending that Abelino be given the job of "General Laborer" with "light duty work," including a "variety of farm activities during the four seasons in which work varies." The activities specified by the consultant included "hoeing by hand," "trimming raspberry plants," "hand harvest of berries," "machine harvest of berries," and "other general laborer duties as needed." According to this form, "hand harvest of berries" was "light duty work." There was no mention in the report that picking berries involves repeatedly bending at the knees, precisely what had caused and later exacerbated Abelino's knee pain. Though Abelino's care had been transferred to the rehabilitation medicine physician, LNI sent the report to the original urgent care doctor whom Abelino had not seen in months. This

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urgent care physician signed his agreement to the report.

In the next medical appointment, again without a translator, the rehabilitation medicine doctor injected Abelino's knee in several places with locally active steroids. This significantly reduced the pain and swelling in the knee, though Abelino still experienced significant pain later when the physical therapist had him squat or bend. His pain now averaged a 3 or 4 out of 10 on the pain scale. This improvement prompted the physical therapist to point out the irony that the treatment initially requested by Abelino and refused by the physicians had turned out to be most effective. The physical therapist also told me he was concerned that the rehabilitation medicine physician appeared to disbelieve Abelino's indication of pain and instead looked only at the X-ray and MRI. This physician paid most attention to these radiological tests and the findings of her brief physical examination—which are entered in the medical chart officially under the heading "Objective"—and discounted Abelino's descriptions of his own symptoms—which are supposed to go in the medical chart under "Subjective."[15] The separation of "Subjective" (what the patient observes and experiences) from "Objective" (what the physician observes or tests in the body) in the medical chart becomes a permanent record of the clinical gaze. This physician continued to tell Abelino that he must go back to work in order to get better, despite his indications that bending and squatting still caused intense pain.

The filing of the employment plan by the consultant prompted LNI to attempt to send Abelino back to work. This also involved sending the rehabilitation physician a form for a final evaluation. This physician responded on the form that Abelino could return to full duty work. Justifying her decision, she quoted directly from the MRI report that there was "no instability" in Abelino's knee. This effectively and immediately closed Abelino's LNI claim, his minimal worker's compensation checks, and the coverage of his medical care. Without fully understanding the LNI process and her direct role in terminating Abelino's benefits, this physician explained to me in private that Abelino described an improvement in his knee after the injections, not because he really got better, but rather because "the picking season is over and therefore he can no longer have worker's comp."

After going to Oregon and California for the winter and spring, Abelino returned to the Tanaka farm in summer. He attempted to pick berries for two days, but the intense pain and swelling in his right knee returned. Abelino appealed, with the help of a bilingual physician at the migrant clinic, to reopen his claim. The physician at the migrant clinic indicated that Abelino's knee was now more swollen and his range of motion was

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decreased since the year before when his claim was closed. LNI set up two independent medical evaluations. These evaluations summarized the previous MRI findings incorrectly in their report to LNI as "entirely normal." The section of the report titled "Socioeconomic History" indicated only "married with eight dependents, has six years of schooling, no military service, no tobacco, alcohol, or medications, including prescribed medications," with no mention of his living or working conditions. They concluded that his knee was "probably not worse" and ordered another MRI, stating that the decision to close the claim should be based on the findings of this MRI. In this way, the biotechnical scan read by a radiologist who would never meet or examine Abelino would trump the physician's as well as the patient's accountings of what happened. The radiologist's MRI report stated that the knee swelling "had not worsened," that Abelino might have degenerative arthritis, and that—though radiologists are not trained or certified in occupational medicine—"the claim can be closed." On the basis of this report, LNI denied Abelino's appeal. The letter sent to Abelino said in English that his claim would remain closed and concluded, "Best wishes with your further health, employment and safety." Years later, Abelino still tells me that he has knee pain and that "doctors don't know anything" (los médicos no saben nada).

After considering in some detail the course of Abelino's interactions with health care institutions, this common statement makes more sense. Several assumptions were made along the way, from the absence of stomach problems to his first return to work being "light duty," from his ability to read English to his being paid as an hourly worker, from his incorrect picking as the cause of his injury to his faking of the pain, from the importance of "Objective" biotechnical tests to the disqualification of his words and experiences. Several of these assumptions were made into fact via their inscription in charts and reports that were later picked up and incorporated by other officials. Some of the actions of the health professionals might be considered bad medical practice (such as giving a contraindicated medication without first asking thoroughly), though all are likely the outcome of an impossibly hectic, understaffed, underfunded, and impersonal health care system.

This ethnographic vignette brings into relief three important aspects of the clinical gaze in the field of migrant health to which I return below. First, as might be expected in Foucault's paradigm of the clinical gaze, physicians in migrant health—as in other biomedical spaces—value their own observations and biotechnical testing of the patient's body over the words of the patient. Abelino's descriptions of his social and employment history receive little attention, though international market asymmetries

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and local discriminatory practices placed him in the labor position that caused his injury in the first place. Similarly, his descriptions of his bodily experiences are considered suspect. In the end, simplistic interpretations of the radiological studies, inscribed as truth in the medical record, functioned to justify the physician's decision to send Abelino back to picking and LNI's decision to close his file. Second, physicians in migrant health—as in other clinical sites—may inadvertently blame their patients for their suffering. Lacking the time to fully explore the problem and unable to see the transnational and local structures affecting Abelino's body, the rehabilitation medicine specialist indicated that Abelino's pain was the result of his behavior; that is, he was "picking incorrectly." Third, structural violence victimizes not only the poor and the patient but also, though in a different fashion, the professional, the physician. As can be seen in this vignette, the physicians worked in busy, hectic environments with only partial information about the patient and the institutional process. They had to fill out multiple bureaucratic forms, perform an examination and an interview, and formulate and enact a plan within a ten- to fifteen-minute appointment. The pressures of the current neoliberal capitalist system of health care and its financing force health professionals into a double bind. Either they spend the time and energy necessary to listen to and fully treat the patient and put their job and clinic in economic jeopardy, or they move at a frenetic pace to keep their practice afloat and only partially attend to the patient in their presence.

## THE FIELD OF MIGRANT HEALTH

Before moving on to the health care experiences of Crescencio and Bernardo, I want to explore the general social and cultural context in which clinicians in the field of migrant health work. On Thanksgiving, 1960, CBS News broadcast a program titled "Harvest of Shame." This show was part of a national movement to raise awareness about the poor living and working conditions of what became known by governmental agencies as "migrant and seasonal farmworkers." At this time, most migrant farmworkers were white people known as "dust bowl migrants" from the Midwest and black people from the East coast.

Largely in response to this movement and the discussions it provoked, Congress passed the Migrant Health Act in 1962, which modified the Public Health Service Act to create the Migrant Health Program, providing grants for medical and social services to migrant farmworkers. Since the act's passage, there has been controversy over the changing ethnic makeup of farmworkers and whether or not to include Latin Americans in

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the definition of migrant and seasonal farmworkers. However, the terms *farmworker* and *migrant worker* currently connote almost exclusively people of Latin American descent. The Migrant Health Program currently provides grants to over four hundred migrant health clinics in forty-two states. "Migrant health" has become increasingly recognized as a field within health care since the beginning of this program. This field is generally understood today to apply to Mexican and Central American migrant workers. In 1984 the Migrant Clinicians Network was established to link and educate clinicians who work with these populations.[16] The Network currently has over two thousand members nationwide.

In each of the three major sites of my fieldwork, there was one primary medical institution that my Triqui companions visited for health-related issues. In the Skagit Valley of Washington, there is a federally funded migrant health clinic with six physicians, one nurse-practitioner/midwife, two dentists, two health educators, six nurses, and several administrative staff members. The physicians were an idealistic white woman who graduated from a top medical school; a white woman who grew up in South America, the daughter of Christian medical missionaries and a graduate of another top medical school; a white male mountaineer who enjoyed living close to the North Cascade Mountains; a woman of Central American descent who grew up in the region; and a retired white monolingual English-speaking man working on a locums (daily) basis. The nurses were primarily Latina women from the area as well as a black woman who moved to the area to be close to her family. The migrant clinic charges are based on a sliding scale, with most undocumented Mexican farmworkers earning well under the lowest threshold, thus having a $15 copay for each visit. In the past, the clinic was open two nights a week after 5:00 p.m. Recently, the clinic schedule was changed from being open two nights a week until 7:00 p.m. to now being open one night a week until 9:00 p.m. This schedule change, as well as the mission of the clinic to treat all the local poor instead of solely migrant farmworkers, has led to a correlated decrease in the percentage of patients involved in farmwork. On any given day, one is just as likely to see poor white area residents as poor Mexican migrant workers in the clinic's waiting room.

In the Central Valley of California, there is one primary federally funded migrant health clinic that my Triqui companions visited. This clinic had four physicians, eight nurses, one dentist, and several administrative staff members. Most of the clinic staff were Latinos who grew up in the Central Valley. One physician was from South America and was required to work at a federally qualified community health center until his immigration documents were finalized. The clinic charges are based on a sliding scale,

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with the lowest copay set at $30. The patients of this clinic are a mixture of Latino U.S-citizen area residents and Mexican and Central American migrant workers. Because the copay was twice as high, my Triqui companions went to the clinic in California less often than the one in Washington.

As noted previously, in San Miguel there was one federal Centro de Salud staffed alternately by the visiting medical resident and the visiting nurse, often with no staff for a day or two in between. Both the resident and the nurse were from Oaxaca City and spoke only Spanish. Several Triqui families from the border areas of their towns have moved to larger, primarily mestizo cities in the state of Oaxaca due to the border violence related to land claims. In each of these cities, there is one federal clinic as well as several private physicians with their own practices. The other two major Triqui towns had been downgraded by the federal government from being county seats and, therefore, had lost the funding for their clinics. My Triqui friends explained that there had been too much political organizing in the other Triqui towns, and the Oaxacan state government had responded by demoting those towns such that they now fell under the political jurisdiction of nearby primarily mestizo county seats. In addition to clinics, my Triqui companions sought help from traditional Triqui healers. As seen in the health care experiences of Abelino described above, traditional healing practices are performed not only in Oaxaca but also among Triqui migrant farmworkers in the United States.[17] Notably, the monolingual Triqui-speaking elderly father of the town síndico is a traditional healer in San Miguel. In addition, Crescencio is an apprentice healer who is not yet widely recognized.

## STRUCTURAL FACTORS AFFECTING MIGRANT HEALTH CLINICIANS

Biomedical professionals in the field of migrant health work under demanding and difficult circumstances. Most clinics serving migrant farmworkers are nonprofits with unreliable and changing sources of funding, and many lack certain expensive medicines and medical instruments. Physicians and nurses in these clinics perform many extra duties, from requesting free medicines for their patients to filling out paperwork for discounted perinatal care for expectant mothers. These clinicians often feel hopeless as they witness the systematic deterioration of young, healthy people who come to the United States to work on farms. Dr. Samuelson, the physician and mountaineer in the migrant clinic in the Skagit Valley, spoke about the frustration of seeing his patients' bodies deteriorate over time.

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> I see an awful lot of people just wearing out. They have been used and abused and worked physically harder than anybody should be expected to work for that number of years. Then they come out with this nagging back pain. You work it up, and it's not getting better, and you don't think there is any malingering going on. It gets to the point where you just have to give them an MRI scan, and their back is toast. In their early forties they have the arthritis of a seventy-year-old, and they're not getting better . . . . They're told, "Sorry, go back to doing what you're doing," and they're stuck. They're screwed, in a word, and it's tragic.

Several clinicians also pointed out the difficulties caused by racism in the clinic waiting room. Physicians and nurses spoke of white patients telling them such things as, "I can't come at that time because I don't want to be in the waiting room with those people," meaning Mexican migrant workers. Some white patients complained about the smell of the farmworkers after picking, and some complained that the farmworkers always brought their children with them.

Only approximately 5 percent of undocumented migrants nationwide have health insurance, and most do not qualify for Medicaid or Medicare due to their immigration status.[18] This means not only that many clinics are reimbursed for few of the services they provide but also that there are many obstacles to providing high-quality care. The low level of reimbursements means that such clinics must repeatedly apply for grants from various public and private sources in order to stay afloat. Given the uneven levels of funding, clinic administrators must cut important programs from time to time when funding is low or when the priorities of funders change. To compensate for the shortfalls, the physicians and nurses spend a lot of time and energy trying to obtain samples or donations of medicines needed by their patients. Dr. Goldenson, the South American physician in the migrant clinic in California, told me about a patient of his who got valley fever (coccidiomycosis) from working the fields of the Central Valley. This potentially fatal lung infection is caused by breathing in soil and is therefore a significant concern among farmworkers. Dr. Goldenson had two migrant farmworker patients with valley fever over the previous three years. Both will require suppression therapy with an expensive antifungal antibiotic for the rest of their lives. Dr. Goldenson described one patient's progress.

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> He's not doing as well. . . . But at least he's surviving. Basically, he's going to need $1,000 a month of Diflucan for life. Of course this guy cannot afford even $100 a month. So far, we were able to get MediCal to cover it, although every month I have to go through reapprovals. . . . Quite often I have spent more time trying to get samples. I'm calling friends or looking for special programs. It's a lot of work, but you feel good about it, because these are people who really appreciate that.

The need to make enough money to survive and the lack of flexibility in farmwork schedules make it difficult for migrant farmworkers to take time off to go to the clinic during the day. This encourages the workers to wait until they are very sick before going to the clinic and forces them to miss appointments on days when picking goes later than expected. Clinicians told me on several occasions how difficult it was to treat migrant workers effectively given that they do not make use of preventive services and often miss appointments. Continuity of care is also very difficult to ensure because most migrant workers move to different towns every few months. This means that a new source of discounted or free medicines must be found by the clinicians in each new town. Dr. McCaffree, a thirty-something female physician in the Skagit migrant clinic who grew up in a missionary family in South America, told me, "Most [migrants] don't have any insurance, so that's even harder, 'cause you start them on a medication and you know they're just going to be off it again wherever they go next." The migratory nature of farmworkers' lives also means that their medical records are extremely patchy. Each clinic has at least one medical record for each patient that covers only the seasons during which she or he lived in that area. Many clinics have more than one record for each patient due to confusion over whether the record should be alphabetized by maternal last name, paternal last name, or spouse's last name as well as direct mistranscription of names in Spanish. In addition, some undocumented patients give nicknames or false names for fear of their information being turned over to the Border Patrol.

Language differences complicate the field of migrant health on several levels. Most clinicians are bilingual in English and Spanish; however, some, like the locums doctor in the Skagit Valley, need a translator when they see Spanish-speaking patients. Often clinicians with poor Spanish-language skills do not have time to get a translator and instead conduct the appointment in English, which the patient cannot understand, or with an untrained interpreter—for example, the child I observed translate during

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her mother's gynecological exam. One Triqui patient I know gave premature birth to a baby girl. The nurses wrote, "Patient refuses breast pump," though they did not have a translator with them when they had the interaction that brought them to this conclusion. The hospital social worker who pointed this out to me said, "I can only imagine what she thought they were saying as they gestured toward her breasts with the electric machine." The nurse-practitioner/midwife in the Skagit Valley told me about the ways in which language differences and lack of time and personnel lead to poor care: "There are a lot of staff who don't want to be bothered getting a trained interpreter. People grab me and say, 'Oh, could you be an interpreter?' This person has a right to get a real interpreter and not a five-minute discussion with me when I am running from patient to patient. It's just reluctance. It's just that one more step. It's racism. It's being overworked because our system is a total train wreck right now." "Are you sure you want to be a doctor?" she asked.

Very few migrant clinics offer services in languages other than Spanish or English. The hospital in the Skagit Valley, where my Triqui friends went when they needed inpatient services, offers Mixtec translation through a local nonprofit language service. However, a Mixtec translator is often called when hospital staff find out a patient is from Oaxaca, even if the patient speaks only Triqui. In addition, several clinicians indicated that it is especially hard to communicate with Oaxacan women. Fewer Triqui women have attended school in San Miguel than Triqui men, and as a result some do not speak Spanish. In addition, clinicians complain that Oaxacan women speak quietly and do not look them in the eyes.

Sometimes, assumptions about language and lack of interpretation have even more dire consequences. One Triqui man, Adolfo Ruiz-Alvarez, was held in an Oregon state mental hospital and medicated for over two years after being interviewed only in Spanish and then charged with trespassing and public indecency.[19] According to my Triqui companions, because Mr. Ruiz-Alvarez could not communicate in Spanish, which it was assumed was his native language, he was thought to be crazy. When I heard about this case, I remembered that several times while homeless in California during my fieldwork I could have been charged with public indecency for relieving myself in a public park after the toilets were locked at sundown. My Triqui companions also described the case of a Mixtec man, Santiago Ventura Morales, who was charged with murder without Mixtec translation. Mr. Ventura Morales was held in an Oregon state prison for four years before a nonprofit agency advocating for indigenous Mexicans provided interpretive services that led to his case being overturned.[20]

Clinicians in the field of migrant health work in difficult environments

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that require extra time and work procuring medicines, dealing with the racism of their patients, and working in several languages, all the while lacking reliable resources. Despite feeling overworked, powerless, and sometimes hopeless, they also feel a commitment to work with this population. Many described Latin American migrant farmworkers as deserving high-quality care, and most described feeling a calling, a vocation, to provide quality health care to this population. As Dr. Goldenson put it, "It's a very difficult problem. We have a bad insurance crisis and health care crisis. I mean, citizens cannot really afford health care. And the migrant workers, I truly believe they should have at least the same access as the others. I mean, this work that they are doing is something that nobody else is willing to do. That's the truth. That's probably the only reason why we are able to go to the supermarket and buy fruit for a fair price. So this is a group of people that really deserves our attention."

## CRESCENCIO'S HEADACHE: STRUCTURE AND GAZE IN MIGRANT HEALTH CARE

The last chapter left Crescencio describing his headaches to me after the health fair in our labor camp. He said he developed these excruciating headaches after being called racist names and treated unfairly on the job and explained that he wanted treatment before he might become agitated or violent with his family. He explained that he had seen several physicians in the United States and Mexico as well as a traditional Triqui healer, but none of their therapies had been effective over the long term. He asked me if I had any medicines I could give him. Not knowing what else to do, I suggested Crescencio go to the local migrant clinic to see if they could try something new for his problem. I remembered the algorithm for headache diagnosis and treatment that I had learned in medical school and wondered if the doctors in the migrant clinic might use something similar, moving through trials of medications for tension, cluster, and migraine headaches. A week later, Crescencio told me that he had seen one of the doctors in the clinic but that she didn't give him any medicines. He said that she had referred him for therapy and asked me what that meant. I described paying someone to sit with you, ask you questions, and listen to your answers in order to help you work through your feelings and thoughts and help you decrease your unhealthy use of substances. At the same time, I knew he barely had money to go to the clinic the first time, and it was unlikely he would spend $15 a session for psychotherapy or substance abuse therapy (though that would seem a bargain to others).

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After several weeks of trying to make an appointment with the doctor who saw him at the migrant clinic, I was able to ask her about Crescencio's headache. She thought for a minute and then looked at Crescencio's chart to refresh her memory. She told me that she met with him once briefly over a month ago. She had asked him to cut back on his drinking and then return to see her for further evaluation. However, he ended up returning at a different time and seeing a different doctor, the locums physician who spoke only English. After looking at her chart note and the notes from the locums physician, she told me about Crescencio's situation from her perspective.

> Well, yes, he thinks that he is the victim and thinks that the alcohol or the headache makes him beat his wife . . . but really he is the perpetrator and everyone else is the victim. And until he owns his problem, he can't really change.
>
> I'm on the CPS [Child Protective Services] subcommittee, and so I've learned a lot about domestic violence. What we've seen is that nothing really works, none of these migraine medicines or anything, but to put people in jail because then they see a show of force. That's the only thing that works because then they have to own the problem as theirs and they start to change. It's a complex psychosocial problem, a patterned behavior. Probably his dad treated him this way, beat him, and was alcoholic, and now that's what he does. It's a classic case of domestic abuse.
>
> He came to see me once, and I told him to come back two weeks later after not drinking. But he didn't come back two weeks later. Instead, he came back a month later and saw one of our locums. Apparently, he told the doc something about when people at work tell him what to do, it makes him mad, and that's what gives him a headache.
>
> Obviously he has issues. He needs to learn how to deal with authority. We referred him to therapy. Do you know if he's going to therapy?

As in Abelino's health care experiences, this doctor was pressed for time and made assumptions without fully exploring the patient's psychosocial realities. In Crescencio's case, the physician made the assumption that his description of feeling agitated and angry indicated that he had already beaten his wife and continued to beat her. Without enough

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time to pay full attention to the patient's concerns and focus on the headache and its source, she focused primarily on assumed intimate partner violence. While paying attention to the possibility of such violence is of utmost importance, this focus may have led to a short-circuiting of the treatment possibilities for Crescencio. Without being able to explore all the possible therapies for severe headeaches, the physician retrospectively advocated incarcerating people like Crescencio.

After reading in the chart that Crescencio's headaches were due to mistreatment from supervisors on the farm, the physicians recommended therapy to help him overcome his "issues" with authority and treat his substance use. Without the lenses to see that Crescencio's suffering was determined by multiple levels of social inequality and disrespect, they inadvertently blamed the headache on the patient's psychological makeup. In the end, their primary interventions were twofold. First, they told him to stop drinking cold turkey, even though drinking was the only effective intervention he had found after years of active searching. Unfortunately, though perhaps expectedly, he was not able to stop drinking. Second, the physicians referred him to therapy, without the patient understanding what this meant. Therapy performed in order to help a patient accept poor treatment from supervisors may be helpful to the patient in developing coping mechanisms in the midst of a difficult situation. Substance abuse therapy may help a patient reduce the harm of substance use and develop healthier behaviors. At the same time, therapy may also promote the patient's acceptance of his place in a labor hierarchy that may include the disrespect and racist insults that Crescencio experienced. In this way, the migrant clinic's interventions were not only ineffective but also inadvertently complicit with the social determinants of suffering, serving to reinforce the social structures producing Crescencio's labor position and headache in the first place.

Crescencio's headache is a result most distally of the international economic inequalities forcing him to migrate and become a farmworker in the first place and more proximally of the racialized mistreatment he endures in the farm's ethnicity and citizenship hierarchy. These socially produced headaches lead Crescencio to become agitated and angry with his family and to drink, thus embodying the stereotype of Mexican migrants as alcoholic and potentially violent. The racialized mistreatment that produces his headaches is then justified through the embodied stereotypes that were produced in part by that mistreatment in the first place. Finally, due to powerful economic structures affecting the migrant clinic as well as limited lenses of perception in biomedicine, this justifying symbolic violence is subtly reinforced throughout Crescencio's health care experiences.

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## THE GAZE OF MIGRANT HEALTH CLINICIANS: WASHINGTON AND CALIFORNIA

The importance of perception in social interactions cannot be overstated. Social scientists have shown the significance of social perception in such diverse contexts as the effects of representations of "the poor" in international development,[21] the results of symbolic linkages between gender hierarchies and human cells in medical science,[22] and the consequences of class-related meanings of smell.[23] The French sociologist Pierre Bourdieu states that "being is being perceived."[24] In other words, human beings are defined through perception by others. This perception or identification[25] determines the actions of other people toward an individual. These actions, in turn, shape the actions of this individual herself insofar as she acts in response to others and insofar as her potential actions were produced or constrained by the actions of others. In addition, these perceptions and actions affect the material conditions in which this individual lives insofar as those conditions are continually produced by social actions on larger political-economic and smaller intimate scales.

The experiences of suffering and sickness of Triqui migrant farmworkers are shaped significantly by responses from medical professionals in the field of migrant health. Understanding these medical responses to Triqui suffering requires an analysis of the lenses through which these health professionals perceive the suffering of their Triqui patients. As the ethnographic data indicate, these perceptions range from positive to neutral, negative to outright racist.

Several medical professionals working in migrant clinics said that migrant farmworkers are a group deserving assistance and are enjoyable to work with. The medical director of the migrant clinic in the Skagit Valley told me that the migrant workers who cross into the United States are "the stars" of Mexico. The midwife in the same clinic told me that they are "the best and the bravest" of Mexico because they have successfully crossed the border and found work in the United States. Dr. McCaffree told me she was continually "amazed by how they keep going" and how they "seem happy and content despite their difficult lots in life." Several clinicians told me that Mexican farmworkers complain less than white patients about their sicknesses and use fewer public resources such as clinic services, welfare, and worker's compensation. Multiple times, physicians and nurses told me that the migrant farmworkers were more respectful and their children better behaved than the white patients in their clinic and that the indigenous Oaxacan people were especially respectful.

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However, clinicians also had complaints about their farmworker patients. One of the nurses in the Skagit Valley told me, “They don’t really take care of themselves,” explaining that they needed to be educated about how “to take care of their bodies.” Dr. Goldenson complained to me that Mexican migrants “don’t think they need medicines.” As an example, he said they often misunderstand the results of untreated diabetes and come to the conclusion that diabetes treatments, like insulin, cause the disease’s sequelae, like blindness and nerve problems. Several physicians also complained about the practices of Mexican patients in relation to traditional healers and so-called culture-bound syndromes such as *susto*.[26] Some clinicians blamed the poor health outcomes of their patients on these beliefs and practices. Johanna, the midwife at the Skagit migrant clinic, told me that she had invented a cure for *sustos* that she considered a great success. The cure involved chamomile tea and rest from household chores. She went on to explain other difficulties she encountered while working with Mexican migrant farmworkers.

> One of the most interesting aspects of working with a Spanish-speaking patient is just this real disinclination to want to be specific and quantify. It’s just enormous. I don’t know if you’ve tried to get a history out of somebody, but if you ask somebody, “How long has this been bothering you?” or “Where does it hurt?” or “What can you tell me about your problem?” what you are going to get is one big basket full of vague stuff. Let’s say you are having a stomachache and, for example, I ask you what is going on and you say, “Well, it started on Monday, and it feels like this, and I have these associated symptoms.” You and I would be on the same wavelength, and that would be very helpful to me. I would be so grateful that you could exactly explain what is going on. In Mexican people, almost to the person, no matter how long you have known them, you are going to get something that is very vague, like, “A while ago, it kind of hurts here, it feels like vaguely aching,” typically minimizing the symptoms. It’s just really hard to get a good history and there are a lot of ideas that I have.

Johanna said she thinks this problem relates to a lack of good health care in Mexico and a religious shame about sickness being related to personal sin or moral failing. At the same time, this communication problem could very well relate more to misunderstandings across class differences than across nationalities or ethnicities. As a crude example, the Mexican

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physicians and nurses I know would respond to these questions in much the same ways I would because of their education and professional background, unrelated to the language they speak or their nationality.

Most clinicians indicated that the primary health problems of migrant farmworkers included diabetes, body pain from work, work-related injuries, and dental problems. The medical director of the migrant clinic in Washington stated that in response to her question, "Are you okay?" many of her migrant patients often reply, "Well, it all hurts, but that's just the way it is." A retired dentist told me that Mexican people wait a long time to go into the dental clinic so that the problems are often so serious that he has to extract their teeth. He explained also that working with Mexican patients was difficult due to what he perceived as ethnic bodily differences: "It's genetics. Their bone structure's just different; it's like you're trying to pull the tooth out of granite. You pray it'll lift. Your right arm gets about three times the size of your left. You'll see that in a lot of Mexican people, you know, big jaws or real heavy bone structure. Northern Europeans have much lighter features." On the other hand, the physicians in the migrant clinics told me that the dental problems of migrant workers were the result of being given juice too often in their baby bottles.

Johanna, the midwife, told me that she sees a lot of domestic violence perpetrated by the men against their wives. Her theory was that much of this violence comes from men's deep disappointment about unmet expectations in the United States. Some of the nurses in the same clinic, however, told me that there is very little domestic violence among migrant farmworkers. Dr. McCaffree added that she sees a high rate of unwed pregnancy and a high rate of depression. The depression, she told me, is masked as alcoholism in the men and as vague aches and pains in the women. All the other clinicians told me that the migrant workers had lower rates of substance abuse than their U.S. citizen patients. At the same time, Dr. McCaffree's nurse explained that she sees a lower incidence of depression among the migrant patients than the white patients. In addition, there is often a misunderstanding about marriage between health professionals and their Triqui patients. The vast majority of Triqui people engage in traditional marriage practices, which involve the male paying a bridewealth of approximately $1,500 in San Miguel or $2,500 in the United States to the family of his fiancée. Most couples do not have an officially recognized church or state wedding. The legal status of this partnering, then, is complicated because the couples do not fill out government marriage forms. Yet for the Triqui people, these are recognized as marriages. Thus many of the "unwed pregnancies" cited by Dr. McCaffree are likely not as simply categorized.[27]

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In addition to the common invalidation of Triqui marriage by health professionals, another intercultural and legal problem surrounding Triqui marriage relates to the ages of the couple. Triqui males routinely marry between the ages of sixteen and twenty, and their female partners are often between the ages of fourteen and eighteen. According to Triqui people and migrant health clinicians in Washington and California, the following is a common occurrence. A Triqui couple goes to the hospital for the wife to give birth to her first child. During the patient interview, the nurses or social workers use simple definitions to determine that the couple is not legally married and then go on to discover that the woman is under seventeen and the man is seventeen or older. The hospital staff then make contact with law enforcement agencies, which is required by law in some states. The woman is placed in the custody of a relative or the court, and the man is convicted of the felony of statutory rape. He is then put in prison (for up to ten years in some states).[28] In 2009 the mainstream English-language media in the United States misrepresented traditional Triqui bridewealth practices in Greenfield, California. Despite the nuanced and contextual statements released by the local chief of police, the mainstream media ran the following ethnocentric story title, "Man Sells Daughter for Money, Beer, and Meat."[29] In fact, it appears that the money, alcohol, and meat was the agreed-upon bridewealth that would allow the wife's family to throw a traditional wedding party. Despite the similarities to mainstream white Protestant marriage traditions that include an expensive wedding party (involving money, beer, and meat), this sensationalist story and the related legal battle were covered nationwide by such news outlets as CNN and the *Los Angeles Times.* Despite this kind of potential misunderstanding, the nursing staff chose not to report the Triqui couples I observed through their first child's birth, though they had undergone a traditional marriage and the ages were as described above. After coming to know the Triqui couples giving birth, the nursing staff considered the story described above a cruel misunderstanding.

The medical director of the clinic in the Skagit Valley told me that a large percentage of worker's compensation claims by white or Mexican people are just "trying to work the system." She went on to explain that many migrants in Texas and California move to Washington because they have heard or experienced that the public health plan is good. On a similar note, several of the welfare agents in Madera, California—including the one who owned the slum apartment in which we lived—told me that there are signs all over Oaxaca telling people to go to Madera because they can get welfare there. Over the course of my fieldwork, however, I never heard a single migrant mention welfare or health plans as a reason for their

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migration. In all my travels through Oaxaca, I never once saw a sign advertising welfare in the United States, much less specifically in Madera, California. In fact, the vast majority of my Triqui companions did not qualify for health and welfare programs in most states because they moved too frequently or were undocumented. Some Triqui families applied for and received basic short-term perinatal nutritional support, though this support proved minimal and the process time-consuming.

One of the physicians in the Skagit clinic told me that Mexican people in the United States misuse the health care system by trying to get multiple opinions on their sicknesses and the appropriate treatments. Dr. Samuelson, the physician at the same clinic who sees the most work-related injury cases, contradicted this in certain ways. He performs many of the independent medical exams of Spanish speakers for worker's compensation in the area. He explained that the language barrier often causes problems with testing the reliability of the patient. In addition, he explained that migrant patients have a different mind-set about pain, and "this is not allowed in the [worker's compensation] industry." He explained that when migrant patients pull away during certain aspects of worker's compensation tests, "it is interpreted as faking pain, while in reality it is fear of pain." "So," he continued, "I will go through the same exam and get completely different results. But the suspicions of malingering have already been raised." For the few undocumented migrants who file worker's compensation claims due to work injuries, this suspicion leads to problems in their permanent files. Thus, Dr. Samuelson explained, it is often necessary for migrant patients to see numerous physicians in order to find one who might treat them with sensitivity.

The health professionals with whom I interacted often noticed other differences between the Oaxacans and the mestizo Mexican migrant farmworkers. Several physicians and nurses pointed out that their Oaxacan patients are poorer than their other patients. Dr. McCaffree told me, "They seem a lot poorer, and so they don't have access [to heatlh care]. . . . Their clothes are a little bit dirtier. They tend to be a lot thinner and not much obesity and clothes that don't get changed a lot." On many occasions, clinicians told me that the health status of Oaxacans is worse than that of other groups. One told me, "They're just sicker and have more body pains." This reflects the health disparities literature discussed earlier in the book.

Clinicians in the field of migrant health in Washington and California hold a variety of beliefs about their Mexican migrant patients. They consider them respectful, tough, and deserving of quality health care. At the same time, many clinicians see the migrant workers as frustrating to

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work with due to their traditional health practices and vague medical histories. Some clinicians make ethnocentric assumptions about their patients, such as regarding the reality of their marriages. Different clinicians hold contradictory views regarding the prevalence of substance abuse, depression, and the use of worker's compensation services in this population. However, these health professionals seem to agree in blaming certain health conditions, such as dental problems, on their patients' bodily makeup and cultural behavior.

## BERNARDO'S STOMACHACHE:STRUCTURE AND GAZE IN MIGRANT HEALTH CARE

Bernardo was experiencing a chronic, constant stomachache that made it painful for him to eat, thus causing him to feel weak and slowly lose weight. Every year before he left Oaxaca to work in a fish processing plant in Alaska, he went through several weeks of injections that he explained made him stronger and gave him an appetite. When he arrived home from Alaska weaker and thinner, he underwent this same series of injections again. He attributed the pain to a lifetime of strenuous migrant work as well as to being beaten by the (U.S.-funded) Mexican military as a suspected member of an indigenous rights movement.

During one season in which he picked berries on the Tanaka farm, Bernardo went to the local hospital to be seen for his stomach pain. He requested medicines to decrease his pain and increase his appetite. Although Bernardo is an elderly Triqui person and speaks very little Spanish, he was seen by an English-speaking physician while his daughter-in-law translated. His daughter-in-law is a Mixtec woman who speaks no Triqui and little English. She did her best translating from Spanish to English. In the chart, the physician defined Bernardo as a "Hispanic" male "who speaks only in Spanish, apparently broken Spanish at that, which is difficult for the Spanish interpreter to understands *[sic].*" Later, the physician indicated his impression: "I must say the history was obtained through an interpreter, and my impression is that the patient tended to perseverate on unrelated things from the questions that were asked, but these were usually not translated to me." With this misunderstood multilayered linguistic barrier, the physician concluded that "he apparently has no past medical history. No medical history." The extent of the social history is summed up in two sentences: "He lives locally. Works as a common laborer." After misunderstanding the translation of Bernardo being beaten, the physician charted simply that Bernardo "is an old boxer and wonders if possibly the blunt trauma to his abdomen could contribute

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to his present condition."

Due to the temporal and linguistic limitations of the medical interview, the physician was unclear about the location and quality of the pain. Bernardo was admitted to the hospital overnight for "chest pain" in order to rule out a heart attack. He was given an exercise test, after which the technician noted that "he has superb exercise capacity" and "this is a low risk heart scan." Bernardo repeatedly explained that he needed medicines to decrease his pain and increase his hunger. He also explained that he needed to be at work on the farm by 3:30 in the afternoon. After undergoing the exercise test, Bernardo refused to give a third sample of blood and undergo ultrasound evaluation because he had to get back to work. Bernardo was required to sign an "Against Medical Advice" form before leaving the hospital and was later sent a bill for over $3,000.

Bernardo's hospital experience exemplifies many of the problems caused by lack of time and lack of skilled interpreters, both due in large part to a health care financing system built on maximizing profit instead of patient care. As a result of these structural limitations, the physician assumed Bernardo was a "Hispanic" Spanish speaker, recorded a very limited social history that ignored his migratory status, and determined that ruling out a heart attack was the only important plan. Bernardo's repeated requests for treatments for stomach pain and for lack of appetite were not acted on. Most poignant and horrifying was the bad faith translation of military torture into Bernardo's categorization in the permanent record as "an old boxer."

During my most recent visit to Oaxaca, I stayed again with Bernardo in Juxtlahuaca and visited the private physician who gives him the injections that Bernardo indicated were the only remedy that helped his pain and weight loss. I interviewed the physician at night while his clinic was closed temporarily due to an electricity blackout. He told me that Bernardo had a peptic acid problem such as gastritis or an ulcer. He suggested that this gastrointestinal problem was due to eating "too much hot chili, too much fat, and many condiments." He continued, "[Indigenous people] also don't eat at the right time but wait a long time in between meals." The physician gives Bernardo a pill to decrease his peptic acid levels. He explained that there were better pills for this, but they were too expensive for Bernardo. He recommended that Bernardo drink milk and eat yogurt to help protect his stomach lining. The doctor also gives injections of vitamin B-12 in order to treat what he considers neuropathy (nerve pain). He explained that this neuropathy was due to the fact that indigenous people "bend over too much at work and bend too much in their sleep."

Like many of the U.S. clinicians, this physician was not able to see

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Bernardo's social and occupational context and instead blamed his suffering on his assumed behaviors and culture. Either the physician was not able to perform a sufficiently extensive intake interview to know about Bernardo's experience of torture or he did not connect this history to the chronic pain. Rather, the practice of biomedicine depoliticizes sickness, functioning in part to erase the structural determinants of suffering such as the political history of military torture and the economic inequalities leading to a lifetime of migrant hard labor.

## THE GAZE OF MIGRANT HEALTH CLINICIANS: SAN MIGUEL, OAXACA

While Bernardo received medical care in a mestizo town due to being displaced by ongoing "land wars," most Triqui people in the state of Oaxaca receive health care through the federally funded Centro de Salud in their home village. Over the course of my fieldwork, I lived in the Triqui village of San Miguel full-time for five months and returned for several shorter visits. During this time, I observed and interviewed the doctors and nurses in the Centro in the middle of town. The Centro consists of a small entryway that doubles as a waiting room and has six chairs, a small examination room, a small room for sick patients to stay overnight on one of two beds (though I never saw this room used), a small bathroom for clinic staff with a flush toilet and a shower, a small kitchen for clinic staff with a gas stove, and a small bedroom for clinic staff. The bathroom receives water from a large black barrel on the roof. The barrel is supplied with water by the mothers in town who are poor enough to be part of the federal Oportunidades program, formerly known as Progresa.[30] This program provides regular, small amounts of money, disbursed through the Centro, for food and school clothing for children. Centro staff require that the women who are enrolled in this program bring a bucket of water in exchange for their disbursements, though this was not a requirement of the federal program. According to the sign on the door, the Centro was open officially seven days a week for drop-in care from 8:00 a.m. to 2:00 p.m. and from 4:00 p.m. to 6:00 p.m., as well as twenty-four hours a day, seven days a week, for emergency care. However, at least half the times I went to the clinic, almost always during drop-in hours, the clinic doors were locked and no one answered to my knocks.

In the waiting area of the Centro hang three large posters for everyone to see. One is a map of the small town with each family's house hand-drawn and marked for the presence of such sicknesses as tuberculosis, diabetes, miscarriage, and malnutrition. One poster is titled, "10 Rights of Patients,"[31] among them, "Receive dignified and respectful attention;

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Decide freely about your medical attention; Decide whether or not to give your consent for risky procedures; Be treated with confidentiality; Receive medical attention in the case of urgency." Of note, the first poster's public announcement of sicknesses directly counteracts the claim of the second poster to the right to "confidentiality." The last poster is titled, "Ten Commandments of the Good Patient,"[32] and includes such things as "Have confidence in your doctor and take the treatments they prescribe; Know that the Health Center is yours and you should take care of it; Ask the doctor how to make it so you do not have more children; Be respectful with the doctors and nurses; Keep yourself and your house clean." The ethnographic vignettes below demonstrate how these contradictory views of the physician-patient relationship—from the surveillance biopower of the first poster to the individualized patient rights of the second to the patron-client sick role of the third—compete with each other in everyday clinical interactions in San Miguel.

Market day in the center of San Miguel, where the Centro de Salud is located. Photo by Seth M. Holmes.

The doctors and nurses I met at the Centro perceived Triqui people in several different ways. For example, the Centro had recently prepared a

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summary report on the health of the town of San Miguel. The nurse who prepared it listed "lack of family planning by the families" and "not accepting the taking of cervical cytology [Pap smears]" as the two most important health problems. I asked the nurse to explain these problems further, and she explained simply, "They don't give in to it [Pap smears] easily." The report listed "culture and customs" as the reasons for these two problems. It listed 33.6 percent illiteracy as a less important problem and charged that this was "due to the fact that fathers of families prefer that their children dedicate themselves to the fields than to finishing their primary education. . . . Sometimes the father of the family takes the children to the states of Culiacán, Sinaloa, Hermosillo, Ensenada, U.S.A. *[sic].*" A third problem listed in the report was "housing," with the explanation that "promiscuity exists in this population because in some houses, three families live together." The nurse wrote that this crowded housing was due to "customs of the population." For the problem of "pollution," the nurse blamed "burning garbage" and "not always using latrines." In all these examples, Triqui behavior and culture were blamed for health problems and social structures were ignored. In what sense is refusing a Pap smear a more important health problem than the high rates of childhood death due to poverty-related malnutrition and diarrhea? In what sense is it valid to state that parents prefer that their children work instead of making it clear that parents are practically forced to have their children work in order for the children to survive in the midst of international and domestic economic inequalities? As I read the section on overcrowded housing, I wondered again why the nurse listed "customs" instead of poverty, neoliberal corporate capitalism, or social and economic inequalities as the underlying cause.

Every week as I observed interactions in the Centro, the nurse or doctor present told at least one Triqui mother that her child was malnourished. They routinely said things like, "If you feed them more tacos and less Sabritas [brand chips], we wouldn't have this problem," though I never heard them check to see if the family bought chips at all or had money to buy Sabritas. On one such occasion, the nurse castigated a Triqui mother, "Oh, woman, woman! What are we going to do?! Your girl is one year and seven months old and weighs what a girl of six months should weigh! Woman!" In the midst of these interactions, the nurses and physicians use *tú,* the informal version of "you," while the patients respond with *usted,* the formal version. The Centro is required by government policy to weigh and measure all children categorized as malnourished each month until they are considered well nourished. However, the nutrition categories are based on averages as norms, and the malnutrition index is

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based only on weight and height. This index was developed in Mexico City in a primarily middle-class, mestizo population with a different diet and a higher average body mass and height. In front of several Triqui people in the waiting room of the Centro, one of the nurses explained to me that this index did not work well with indigenous people, though it was still required by the health department. Here a medical index developed among one ethnic group and class is applied normatively to another group in such a way that the patients are defined as abnormal, monitored, and, at times, shamed for their assumed behaviors. This practice is an example of structural medical racism and classism at work.

After the nurse explained to me in Spanish the problems with the nutrition index, she went on to tell me in front of the people in the waiting room, "I don't like it here, and I want to leave." She said that she would stay if the Triqui people paid more attention to her and thanked her. During this conversation, she saw the patients in the waiting room without taking them into the examination room for privacy. One of them had flu-like symptoms—aches and pains and a significant fever. The nurse explained to me that the Centro was not stocked with very many kinds of medicines, and she had to give this patient a pain pill "because that's all I have." After she saw these patients, she told those waiting outside that she was closing because she had papers to fill out. Much like the other doctors and nurses I observed, she closed and locked the front doors, pulled the blinds, and turned on music, despite the fact that the schedule on the front door indicated that the clinic was open for drop-in visits for the next two hours. She did not respond the few times I heard knocking at the door of the clinic.

She took me into the kitchen in the back of the building and made us a tripe mole lunch. She continued to describe her experiences living in the village.

> I talked with a friend of mine who is a psychologist, and she told me to find something I like here and to focus on it. I've looked a lot and haven't found anything I like. I don't like the land, or the climate; the people even worse! The people here are lazy, dirty, ignorant, mean gossipers. I used to work in another town where the people were clean. Yes, there was running water there, but still the people were clean and combed their hair! Here, the women just pee wherever they want to. No wonder they have respiratory illnesses here if they pee everywhere and then the wind blows dust around. I told a woman to comb her daughter's hair so that she would look

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pretty, and the woman said, “No, that is not good; we are Triqui.”

The people here are traitors, don’t trust them, Set’. They might kill you because you say hello to someone and don’t remember to say hello to someone else. I used to work in a town where the climate and the people were warm. Now I am with cold people. Why would I want a friendship with an indigenous person? I don’t need anything from them.

I used to think the indigenous people were so poor and fucked and poor. Now, I know they are just lazy and dirty. I used to want to give my life to help them even if they didn’t pay me and even if they didn’t thank me. Now I won’t give my time or even a peso for a *pueblo* [indigenous town]. Not even one peso! That is bad, huh? But I won’t give a minute or a peso for an indigenous person. They don’t deserve me, and they don’t deserve my friendship.

Do you know why Mexico has a very big debt and doesn’t build roads or anything? It all goes to the pueblos so they can have medicines. It all goes to the pueblos.

And furthermore, they don’t know how to cook! Sometimes, when I give seminars about nutrition, I ask them to bring pumpkin or squash and meat, and I try to teach them to make tamales, but they don’t want them, and they don’t bring the food to cook with. I tell them to make more rellenos or *masitas* or mole, and they don’t even know how to make it! All these plants out here—from radish to mustard greens—they boil the leaves and eat them. That’s their whole world!

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Samuel's sister carrying firewood, returning to San Miguel with Samuel's father after cutting firewood for the day. Photo by Seth M. Holmes.

As we finished lunch, the nurse told me that she has found one older Triqui woman who is very nice to her, tries to get her to learn Triqui, and cooks for her sometimes.

The nurse’s comments show a lack of awareness of social context similar to that described among clinicians in the United States. However, they have more antagonistic affective overtones that may be due to the fact that the federal government makes this nurse leave her home and friends in Oaxaca City for several days each week for work. In addition, with regard to cleanliness, she fails to acknowledge how much work goes into bathing in San Miguel. In this mountain village, one must hike to the bottom of a long, steep hill and carry ten to fifteen buckets of water home from the well each day. This water is used for cooking, for the animals, for drinking, for washing plates and silverware, and for bathing. In addition, one must hike several miles into the communally owned forest, cut firewood with a machete, and carry it back home. One must also hike to a nearby river and wash one of the few changes of clothes one owns. Next, the wood is used to make a fire big enough to cook meals, simmer corn in order to make masa and tortillas, sanitize drinking water by boiling, and prepare water warm enough to bathe in the cold air of the mountain

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village. Next, the bather has to find a location somewhat private enough without dirtying the inside of the house and without making so much mud that the bath is in vain. While in San Miguel, I helped the family with whom I lived harvest and plant corn and take the oxen and goats to pasture each day. For all the above reasons, despite becoming sweaty and muddy from this work, I bathed at most once a week. On the other hand, Centro staff members are able to bathe every day in the shower's running water that is carried regularly by the poorest women of San Miguel.

When I returned to San Miguel on one of my later visits, the nurse was no longer there; she had been asked to leave by the town leaders "because she took too much vacation." The new nurse was a friendly woman, also from Oaxaca City. I met her for the first time with a Triqui friend, Nicolas, whom I had met on the Tanaka farm in Washington. Nicolas asked for her help preparing the health documents needed to apply for residency in the United States. She replied, "Well, I don't know if you really work hard [in the United States] like you say, but I'll see what I can do." While Nicolas was present, the nurse explained that she was an Evangelical Christian. She told me that the Triqui people are mostly Catholic and that "here Catholic means that they pray to images of wood and iron and steel and who knows what else. We just pray wherever we are to the God who is alive, the God who made the wind and the sun. Catholic means you can do whatever you want. You can drink and have lovers and have lots of fiestas, celebrate birthdays and other days all the time."

She went on to tell me, "The customs of the Triquis are virgin; they haven't been changed by anything. They are still the same as they have always been. Some of the Triqui pueblos are pueblos without laws; they just have customs." She then asked me, "So, you are thinking of crossing the border? For them *[motioning with her hand toward the Triqui pueblo],* it is just another adventure, like a lot of their lives are an adventure. You should take some snake antivenom, though." Like Samantha in relation to Abelino's knee, this nurse discounted the suffering of the Triqui migrants, specifically by referring to the difficult and dangerous border crossing as simply "an adventure." In addition, she echoed the social Darwinist understandings of indigenous simplicity heard on the Tanaka farm.

The nurse went on to tell me (in front of Nicolas) that a baby had died in San Miguel a week ago. She explained that the mother of the baby told the nurse she had brought the baby to the Centro and that the doctor thought the baby had a cold and gave her some pills. The nurse added, "Babies can't swallow pills anyway." Several times as the baby continued to get worse the mother tried to find the doctor, but he did not answer the door of

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the clinic. She took the baby to the nearby mestizo town, Tlaxiaco, and the baby died in the hospital from complications of a lung infection. “If we were working in a *ciudad* [city], instead of a pueblo, he would be in jail. If we were both there and gave only *pastillitas* [little pills], we would both be in jail.”

A few days later, the nurse returned to Oaxaca City for the weekend and the doctor returned to San Miguel. The doctor complained to me that the Triqui people do not come to the clinic enough. To illustrate his point he said, “There was a mother who took her baby all the way to Tlaxiaco last week instead of bringing him to me, and the baby died because it took so long to get there.” He then complained about how the Triqui people gossip and start rumors about him not being in the Centro.

The clinicians in San Miguel work in the difficult environment of a clinic that lacks medicines and medical instruments. They are required by the federal government to travel several hours away from their friends and family for several days each week to work in a town where the people speak a different language. Like the clinicians in Washington and California, they lack awareness of the social forces impinging on the health and well-being of their patients. Instead, they tend to blame the sicknesses of their patients on assumptions about their culture and behaviors. They are given and required to employ ethnocentric metrics, such as the malnutrition index. Because of the relative lack of political power of their patients, they are given impunity for what could be considered malpractice. Finally, they perceive their patients through racist metaphors of dirtiness, violence, and laziness that lead them to understand them as not deserving care.

## ACONTEXTUAL MEDICINE AND APOLITICAL CULTURAL COMPETENCY

As would be expected in the paradigm of the clinical gaze, the clinicians I spoke to see the individual Triqui bodies in their offices, yet they are unable to engage the social context that produces suffering. It was only infrequently (e.g., Dr. Samuelson and Dr. Goldenson) that I heard a health professional point out the context in which the person lives: conditions in the labor camp, working conditions, or international economic and immigration policies. Yet these larger political, economic, and social forces are the fundamental causes of their patients’ suffering. At the same time, the health care professionals cannot be blamed for their acontextuality. They, too, are affected by social, economic, and political structures. Much of their blindness to social and political context is caused by the difficult,

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hectic, and emotionally exhausting circumstances in which they work. It is caused also by the way medical science is thought and taught in the contemporary world. Most of these individuals have chosen their positions in migrant clinics because they want to help. They have a great deal of compassion and a sense of calling to this work. Yet the lenses they have been given through which to understand their patients have been narrowly focused, individualistic, and asocial.

Physicians in the United States and Mexico are not trained to see the social determinants of health problems, or to hear them when communicated by their patients. This acontextuality is seen when the sections of medical charts reporting social history entirely exclude social realities and when torture is reported as boxing. They are trained, instead, to give most heed to the "Objective" information provided by their own physical examinations and, more so, biotechnical blood and radiological tests.[33] Thus it is unavoidable that they would fall into the trap of using a narrow lens that functions to decontextualize sickness, transporting it from the realm of politics, power, and inequality to the realm of the individual body. The most upstream determinants of suffering are left unacknowledged, unaddressed, and untreated. Much like the "anti-politics machine" of development agencies described by Ferguson,[34] biomedicine effectively depoliticizes suffering, blaming sickness not on political economic and social structures but rather on individual behaviors, assumed cultural practices, and perceived ethnic body differences.

Beyond this acontextual gaze, physicians in North America today are also taught to see behavioral factors in health—such as lifestyle, diet, habits, and addictions. Behavioral health education has been added as part of a laudable move to broaden medical education within the paradigm of biopsychosocial health first described by George Engel in 1977. However, without being trained to consider the global political-economic structures and local hierarchies that shape the suffering of their patients, health professionals are equipped to see only biological and behavioral determinants of sickness. Symbolically, they are limited to understanding the genesis of sickness as located in the patients: their bodies (the genetics mentioned by the dentist), their behavior (the incorrect bending assumed by the rehabilitation medicine physician), or their culture (the customs invoked by the nurse in San Miguel). Thus well-meaning clinicians inadvertently add insult to injury, subtly blaming their patients for their suffering.

Largely in response to social science critiques of the limited gaze of biomedicine in a multicultural world, biomedical institutions have adopted training in cultural competency.[35] In many ways, the field of cultural

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competency seeks to broaden the clinical gaze in order to avoid ethnocentric assumptions and ineffective interventions. Most mainstream cultural competence training focuses on lists of stereotypical traits of ethnic groups.[36] This focus suggests that the culture of the patient is the problem that needs to be understood and the barrier that should be overcome in order to provide effective health care.[37] In the formulations of cultural competency, the culture of biomedicine and the structural determinants of health and health care are left largely unexamined. However, the ethnographic data above contradict this focus by showing that it is often the structure and the culture of biomedicine that function as barriers to effective care. As suggested by Jonathan Metzl, medical educators should exchange mainstream cultural competency for training in social analysis and "structural competency."[38]

Without appreciating the continuum of violence located in ethnic and citizenship hierarchies and international policies that place their patients in injurious conditions in the first place, clinicians often blame the sickness on the patient—the assumed incorrect manner of bending while picking, the presumed trouble with authority, or the expected inappropriate diet. The way one stands while picking berries, if indeed incorrect in some unhealthy way, is only a proximal ingredient of one's suffering. Ironically, the progressive move to include behavioral health in medical education without the correlate inclusion of social context may be exactly what leads clinicians to blame, even criminalize, the victims of social suffering.[39] Even those health professionals who are acutely aware of the social determinants of health may resort to biological and behavioral explanations as a defense mechanism against that which they experience as hopeless. Thus the victim of prejudice and economic and historical inequalities is blamed for her predicament. She is blamed for the bad jobs and the poor health she has, even though these are outcomes of the social structures by which she is situated.

The reality of migrant health, however, is even more complicated and potentially dangerous. The difficult circumstances and limited gaze of the migrant clinic make it impossible for even the most idealistic clinicians to provide effective treatment. Not only are these physicians unable to recommend appropriate interventions; they often prescribe ineffective treatments with unintended harmful results. Some of these treatments—such as returning a patient with an injured knee to full duty work—can be directly harmful to their patients. Even the interventions of well-meaning physicians—for example, pain-relieving injections and referrals to therapy in order to, among other things, accept potentially cruel treatment from supervisors—may function inadvertently to shore up the unequal social

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formations causing sickness in the first place. These treatments unintentionally depoliticize suffering, thereby buttressing the very structures of oppression causing sickness. The violence enacted by social hierarchies extends from the farm to the migrant clinic and back again, despite the impressive values and intentions of those in both institutions. The structure of health care must be changed to offer quality care to all patients instead of seeking private profit and cost-savings. The contemporary biobehavioral clinical gaze must be transformed to recognize the social, political, and economic determinants of sickness and health, to include structural competency. In the meanwhile, it is no wonder that my Triqui companions conclude that los médicos no saben nada.

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