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The clinical gaze in the practice of migrant health: Mexican migrants in the United States

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ABSTRACT

This paper utilizes eighteen months of ethnographic and interview research undertaken in 2003 and 2004 as well as follow-up fieldwork from 2005 to 2007 to explore the sociocultural factors affecting the interactions and barriers between U.S. biomedical professionals and their unauthorized Mexican migrant patients. The participants include unauthorized indigenous Triqui migrants along a transnational circuit from the mountains of Oaxaca, Mexico, to central California, to northwest Washington State and the physicians and nurses staffing the clinics serving Triqui people in these locations. The data show that social and economic structures in health care and subtle cultural factors in biomedicine keep medical professionals from seeing the social determinants of suffering of their unauthorized migrant patients. These barriers lead clinicians inadvertently to blame their patients – specifically their biology or behavior – for their suffering. This paper challenges the focus of mainstream cultural competency training by showing that it is not the culture of the patient, but rather the structure and culture of biomedicine that form the primary barriers to effective multicultural health care.

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Introduction

Background: migrant health

In the wake of the 2009 health care reform bill in the United States, there are many unanswered questions about health care for immigrants, particularly those categorized as unauthorized. Important unanswered questions include what is the current state of health care for immigrant populations in the U.S. and which health policies would lead to the best health outcomes for these populations. However, the public controversy surrounding unauthorized immigrants and their health care has left these topics largely unexplored.

Recent estimates indicate that there are 293 million U.S. residents, including approximately 36 million immigrants (Espenshade 1995; Migration News 2002). The 2000 U.S. Census estimates there are 4.8 million unauthorized immigrants in the U.S. though others suggest a number closer to 10 million (Espenshade 1995; Migration News 2005). Researchers estimate that there are 1 million indigenous Mexicans from the state of Oaxaca in the U.S. (McGuire & Georges, 2003). In addition, it is estimated that approximately 95% of agricultural workers in the

U.S. were born in Mexico and 52% of them are unauthorized (Frank et al., 2004, Kandula et al., 2004).

Despite a strong focus in public health on what is often called the healthy Latino paradox, much research has shown that farm workers bear an unequal share of sickness. The Latino paradox indicates that there are certain health conditions for which Latino populations overall fare better than other ethnicities despite having relatively lower socioeconomic status. However, there is growing evidence that the micro population of Latino farm workers fares poorly with regard to health status. For example, the fatality rate of agricultural workers is over five times that of all workers (Slesinger 1992). In addition, nonfatal injuries as well as chronic pain, heart disease, many cancers, and birth defects are higher in this population (*Ibid.*). Migrant and seasonal workers have increased rates of many chronic and infectious diseases (Mobed et al., 1992, Rust 1990; Sakala 1987). Finally, unauthorized status is understood by many to increase detrimental allostatic load due to fear of apprehension and traumatic experiences crossing the U.S.–Mexico border (McGuire & Georges, 2003).

Even though unauthorized immigrant farm workers have especially poor health status and need especially strong health service support, this population faces many obstacles to accessing such provisions. The federal Migrant Health Program is estimated to serve approximately 13% of the intended population of migrant laborers (Villarejo 2003). Despite living well below the poverty line, less than one third of migrant women qualify for Medicaid,

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primarily due to their unauthorized status (Kauffold et al., 2004). In addition, researchers estimate that less than 30% of migrant laborers have health insurance, contrasted with an estimated 84% of U.S. residents overall (Health Outreach Partners 2011; Migration News 2004; Villarejo 2003). This disparity is likely to grow with the laudable recent health care reform that promises to increase the rate of health insurance for U.S. citizens with no provisions for one of the most vulnerable populations in the U.S. – unauthorized immigrant workers. Furthermore, it is estimated in California that less than 10% of indigenous Mexican farm workers have health insurance contrasted with 30% of mestizo Mexican farm workers (Indigenous Farmworker Study 2011).

In general, the present study investigates the current state of and barriers to healthcare for unauthorized indigenous Mexican migrant laborers in the U.S. Specifically, this project fills gaps in our current knowledge about the structural barriers to the health care of unauthorized immigrants as well as the perceptions of clinicians working with these populations. Most research on barriers to migrant health care has focused narrowly on the factors that affect the migrant patient's ability to access care. The factors that affect the medical professionals in the migrant clinic have been left largely unstudied despite the importance of this topic. In addition, the perspectives of health care providers are especially important given that they affect the type and quality of care performed. This two-pronged research exploring the structural factors affecting medical professionals in the field of migrant health as well as their perceptions of their migrant patients is necessary in order to understand more fully the institutional, cultural, and psychosocial barriers to health care for this structurally vulnerable population (see discussion of structural vulnerability in Holmes, 2011).

In order to place the barriers to health care of unauthorized migrants in context, the paper will next move to a description of Foucault's concept of the clinical gaze. Then, the paper will move to a brief consideration of the attempt to broaden the gaze through cultural competence training in medicine. The paper next offers a brief vignette of the sickness and healthcare experiences of an unauthorized Triqui migrant research participant. After the Methods section, the paper moves onto the Results section, which is broken up to consider first the context of the migrant clinics in the research, then the structural and next the perceptual inputs into the practice of migrant health, followed by a brief presentation of the health care experiences of migrant patients. Next, the paper moves into the Discussion section to analyze the clinical gaze in migrant health as simultaneously reductionist and idealistic. The paper concludes with a brief reflection on the implications of this research for public policy, clinical care, and medical education.

The clinical gaze and cultural competence

One of the most important social theories on the perceptions of medical professionals in the clinical encounter comes from Michel Foucault in *The Birth of the Clinic* (1994 [1963]). In this book, Foucault describes what he calls "the gaze." He indicates that the clinical encounter changed drastically between the 18th and 19th centuries.

"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?'" Foucault 1994 [1963] p.xviii

According to Foucault, the conception of disease transformed from an entity present throughout the whole person to a lesion localized anatomically. Foucault indicates that it was no longer necessary for doctors to listen to patients describe their experience of the illness in order to diagnose and treat. Instead, they began to

focus on the diseased organs, treating the patient more as a body, an object, while ignoring the social and personal realities of the whole person, the patient.

Largely in response to social science critiques of the limited gaze of biomedicine in a multicultural world, biomedical institutions have adopted trainings in cultural competency (c.f. Kleinman & Benson, 2006). In many ways, the field of cultural competency seeks to broaden the clinical gaze in order to avoid ethnocentric assumptions and ineffective interventions. Most mainstream cultural competence trainings focus on lists of stereotypical traits of ethnic groups (Jenks, 2011). This focus implies that the culture of the patient is the problem that must be understood and navigated in order to provide effective health care (Jenks, 2011; Shaw and Armin, 2011). In the formulations of cultural competency, the culture of biomedicine is left largely unexamined.

In the current research project, the theory of the gaze might prompt the following questions: What are the characteristics of the gaze within a contemporary migrant clinic? How does the gaze in this context differ from that described by Foucault? How do the characteristics of the gaze in migrant health relate to barriers to care? What are alternative models for interactions and perceptions in the migrant clinic? How might these alternatives relate to or differ from mainstream cultural competence approaches?

Introductory vignette: "the doctors don't know anything"

One morning in the middle of my first summer of field research on a berry farm in northwestern Washington State, I followed Abelino, his wife and their oldest daughter into the field we were to pick that morning. Abelino's family lived in a shack near mine in the farm's migrant labor camp. It was pitch black before sunrise and we wore warm clothes in layers to take off as the sun came up. We were assigned rows next to each other and began picking into our individual buckets without saying a word. We picked as fast as we could while squatting, alternating back and forth between rows of berries on either side of us.

Several hours later, in the middle of one of the rows, Abelino felt acute, intense pain in his right knee one of the times he pivoted from the right to the left. He attempted to keep working for the rest of the day in vain hopes that the pain would go away. Two days later, a heavy, cold downpour caused work to be canceled on the farm. Abelino and I went into an urgent care clinic. Over the course of the following several months, he ended up seeing several doctors and a physical therapist, usually without a translator in Spanish, never in his native language of Triqui. After several months of these health care interactions, Abelino still told me that he had knee pain and that "the doctors don't know anything (*los médicos no saben nada*)."

This statement took me aback. I wondered whether it was due to a difference in illness explanatory models (Kleinman 1988) between an indigenous Triqui person and American biomedical physicians, an appropriate judgment of the lack of knowledge of particular physicians, or the inability of knowledgeable physicians to enact meaningful change in the lives of their migrant patients. I hoped, regardless of the final reason for the statement, that the statement was specific to this particular case.

However, as I continued my fieldwork in Washington State, California, Arizona and Oaxaca, Mexico, I heard that "*los médicos no saben nada*" (the doctors don't know anything) in several contexts. I found this refrain quite disconcerting. I was in the midst of training to become not only an anthropologist but also a physician and I wanted to work in both capacities in the future. This refrain brought up several questions for me, which formed the impetus for the current study. Why did the Triqui people understand physicians to know nothing? What had gone wrong with the physician–patient

relationship? How might the problems with this relationship relate to the gaze of medical professionals in the field of migrant health? And how might social science research speak to clinical medicine and public health in a way that is for the Triqui people?

Methods

Study participants were selected to form a representative sample and to develop organic fieldwork rapport (Holmes 2006). Participants included fifty unauthorized Triqui indigenous Mexican farm workers as well as thirty health professionals working regularly with migrant patients (see Fig. 1). The unauthorized Triqui farm worker participants were selected to represent all demographic groups who migrate along a transnational circuit (Rouse 2002) from the mountains of Oaxaca, Mexico, to central California and northwest Washington State. The primary investigator is fluent in English and Spanish and speaks common phrases and words in the Triqui language spoken by this group. The health care providers sampled included eighteen physicians, ten nurses and two dentists. They were selected to represent the primary types of health care providers involved in the clinics in which the Triqui migrants accessed health care along their migration circuit. Names of all study participants have been changed without changing the nature of the data.

This study utilizes the method of participant observation (Hammersley & Atkinson, 1995) as well as tape-recorded in-depth interviews with principal migrant laborer and health professional study participants. Physician–patient interactions were observed in clinics and hospitals serving migrant patients one to two days per week as well as any time a Triqui migrant study participant sought and received medical care. Tape-recorded interviews were conducted in Spanish with Triqui migrant participants who experienced health problems requiring significant interactions with biomedical care as well as in English with their health care providers. The methods of long-term participant observation and in-depth interviews were chosen to investigate the subtle interactions, perceptions, and experiences important to the field of migrant health care that are not easily analyzable via surveys or other quantitative methods. These multi-faceted long-term qualitative methods are necessary to investigating such subtle and complex social phenomena without simplifying the intricate sociocultural realities in which they are embedded.

LOCATION	PARTICIPANTS
Washington State	30 Triqui migrants
	8 physicians
	5 nurses
	2 dentists
Central California	20 Triqui migrants
	7 physicians
	4 nurses
Oaxaca, Mexico	20 Triqui migrants
	3 physicians
	2 nurses

Fig. 1. Ethnographic research participants.



Fig. 2. Map of migration route during research.

The multi-sited fieldwork (Marcus, 1998) was conducted full-time over eighteen months in 2003 and 2004 throughout the migration circuit of the indigenous Triqui Mexicans beginning on a berry farm in northwest Washington state, migrating to central California and then to their home village in Oaxaca, Mexico, trekking across the border into Arizona, and returning once again to central California and Washington state (see Fig. 2). Shorter visits were made from 2005 to 2007 to each primary field site. Participant observation involved seven months living in a farm migrant camp, picking strawberries and blueberries, as well as observing migrant clinic interactions in northwest Washington; five months living with Triqui laborers in a slum apartment, pruning vineyards, and observing in a migrant clinic in central California; five months living with a family in a village in the mountains of Oaxaca; and one month interviewing Border Patrol agents and local residents as well as trekking across the desert from Mexico into southern Arizona. The long-term, multi-sited fieldwork allowed for a more broad and in-depth understanding of the lives and health needs of the Triqui people. The study was explained and participants were enrolled as approved by the Committee on Human Research of the University of California San Francisco.

The model of grounded theory (Strauss & Corbin, 1990) provided a helpful overview for data analysis in this study. Regularly during fieldwork, the primary investigator coded and analyzed field notes and interview transcripts in order to test the primary hypotheses and refine them for the next phase of participant observation and interviews. Field notes and transcribed interviews were coded, compiled, and analyzed for their characteristics and meanings. Data were also coded axially in order to analyze connections among categories. The technique of triangulation – the analysis of several types of data from the same source over time as well as from independent sources – was employed to verify the validity of research findings and diminish bias due to self-report alone.

Results

The migrant clinics

In each of the primary sites of migration, there was one primary medical institution with which my Triqui companions interacted. In the Skagit Valley of Washington State, there is a federally-

funded migrant health clinic with five physicians, one nurse practitioner midwife, two health educators, six nurses, and several administrative staff. The physicians include the Chief Medical Officer, a middle-aged, white, idealistic female (whom I call Dr. Nelson) who graduated from a top medical school and started the clinic to help underserved populations; a young white woman who grew up in South America as the daughter of Christian missionaries who graduated from another top medical school (whom I will call Dr. McCaffree); and a middle-aged, white male mountaineer who was happy to live in the area to be close to the North Cascades (whom I will call Dr. Samuelson). The nurse practitioner midwife is a middle-aged, tall, and relaxed white woman who has worked in the area for many years (whom I will call Johanna). The nurses were mostly Latinas from the area as well as one black woman who moved to the area to be close to family. There are two private dental clinics in the area to which most migrant patients are referred and where they are charged a discounted fee. In the medical clinic, charges were based on a sliding scale with most unauthorized Mexican farm workers making well under the lowest threshold and, therefore, paying \$15 for a visit. The clinic is open 9 to 5 everyday except Wednesday, when it stays open until 7pm.

In the Central Valley of California, there is one primary federally-funded migrant health clinic that my Triqui companions visited. It has four physicians, eight nurses, one dentist and several administrative staff. Most of the clinic staff are Latino/a people who grew up in the Central Valley. One physician (whom I will call Dr. Goldenson) is from South America and is required to work at a federally-qualified community health center until his immigration documents are finalized. The clinic charges are based on a sliding scale with the lowest charge being a \$30 co-pay. Most of the patients of this clinic are Latino/a area residents along with a significant number of Mexican and Central American migrant workers. My Triqui companions went to this clinic less often than they went in Washington State due primarily to the higher co-pay. This study will focus primarily on biomedical professionals in the United States, though the Triqui study participants also maintain concurrent and separate interactions with biomedical professionals in Oaxaca and with traditional Triqui healers in the U.S. and Mexico (Bade 2004; Romanucci-Ross 1969).

Structural factors affecting migrant health clinicians

Medical professionals in the field of migrant health work under difficult circumstances on many levels. Most clinics serving migrant farm workers are non-profits with unreliable sources of funding, and most patients in these clinics lack insurance coverage. Physicians and nurses in these fields perform many duties for which they are not trained, from requesting free medicines from pharmaceutical companies to filling out governmental paper work for discounted perinatal care for expectant mothers. The clinicians often feel hopeless as they see young, healthy people come to the U.S. to work on farms and watch their health systematically decline. Dr. Samuelson, the physician in the Washington State migrant clinic who moved to the area to be close to the North Cascades Mountains, spoke about the frustration of seeing his patients' bodies deteriorate over time.

"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 is not getting better and you don't think there is any malingering going. 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 are not getting better. They are told, 'sorry, go back to do what you are doing,' and they are stuck. They are screwed, in a word, and it is tragic."

Several clinicians in this field also pointed out the difficulties brought on by racism in the clinic waiting room. Physicians and nurses spoke of white patients telling them such things as "I can't come during that time because I don't want to wait in the waiting room with *those* people," meaning Mexican migrants. Some white patients complained about the smell of the farm workers after picking, some complained that farm workers often bring their children with them, and some even threatened that they would not come back if they treated the same as the migrants.

As stated earlier, less than 30% of migrants nationwide have health insurance, and most do not qualify for Medicaid or Medicare due to their immigration status (Villarejo 2003 *Migration News* 2004). This means not only that the clinic is reimbursed for few of the services it provides, but also that continuity of care and medications is practically impossible. The low level of reimbursement means these clinics must 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.

In addition, every day that I observed physician-patient interactions in the migrant clinics, I was impressed with how much time and effort the physicians and nurses spent to obtain medicines for their patients. Dr. Goldenson, the South American physician in California, told me about a patient of his with Valley Fever (Coccidiomycosis). Valley Fever, a potentially fatal lung infection seen primarily in the Central Valley of California, is caught from breathing in soil and is, therefore, a hazard for those people working most directly with the soil, for example migrant farm workers. Dr. Goldenson has had two patients with Valley Fever over the past three years, both of whom will require anti-fungal suppression medicines for life. He tells me the details of one of his patients,

"He's not doing as well. But at least he's surviving. Basically, he's going to need \$1000 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 re-approvals. 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 farm schedules make it difficult for migrant farm workers to take time off for clinic appointments during the day. These phenomena encourage migrant laborers to wait until they are very sick before going to the clinic and force laborers to miss appointments on days when picking goes late. Clinicians told me on several occasions how difficult it was to treat migrant workers effectively given the fact that these patients do not make use of preventive services and often miss appointments. Continuity of care is also very difficult to attain due to the fact that most migrant workers move to different towns every few months. Dr. McCaffree, the white female physician in the Washington migrant clinic who grew up with missionaries, 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 are just going to be off it again wherever they go next." In addition, the migratory nature of the lives of farm workers means that their medical records are patchy. Each clinic has at least one medical record for each patient that covers only the seasons during which they lived in that area. Many clinics have more than one record for each patient due to confusion over the correct

spelling of their name in Spanish and whether the record should be alphabetized by the maternal or paternal last name.

Language differences complicate the field of migrant health in multiple ways. Most clinicians are bilingual in English and Spanish, however some need a translator with Spanish-speaking patients. Often those with poor Spanish language skills do not have easy access to a translator and instead conduct the appointment in English that the patient cannot understand or with an untrained interpreter, such as the patient's young child I observed translating during her mother's gynecological exam. One Triqui participant gave premature birth to a baby girl during the research. The nurses wrote in her chart, "patient refuses breast pump," though they did not have a translator with them when they interacted with this patient. The hospital social worker became upset discussing this case, imagining what the Triqui mother might have thought when the nurses made gestures toward her breasts with the electric machine.

Very few migrant clinics offer services in languages other than Spanish or English. The hospital in the Skagit Valley, where my Triqui friends went if they needed inpatient services, laudably offers Mixteco language translation through a local non-profit organization of interpreters. Due to confusion about indigenous languages, a Mixteco translator is called regularly when hospital staff hear that a patient is from Oaxaca, even if the patient speaks only the Triqui language. Johanna, the nurse practitioner midwife in the Skagit Valley migrant clinic, told me about the problems with the current system regarding language differences,

"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 5-minute discussion with me when I am running from patient to patient. It is just reluctance. It is just that one more step. It is racism. It is being overworked because our system is a total train wreck right now. Are you sure you want to be a doctor?"

Several clinicians mentioned that it is especially hard to communicate with Oaxacan women. Few Triqui women have attended school in Oaxaca such that many do not speak or read Spanish. In addition, some clinicians mention that Oaxacan women speak quietly and do not look them in the eyes.

As seen above, clinicians in the field of migrant health work in difficult environments that require extra work procuring medicines, dealing with racism, and working in several languages, all the while lacking reliable resources. Dr. Goldenson in California explained that,

"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 that 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 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."

At the same time that most physicians in migrant clinics feel overworked and powerless to change the structural forces influencing the health problems of their patients, they also feel a commitment to work with this population. Many voiced the conviction that Latin American migrant farm workers deserved high quality health care and most described a personal sense of calling to serve this population.

Perceptions of migrant health clinicians

Several clinicians in migrant clinics indicated that migrant farm workers are a group deserving of help and enjoyable to work with,

as is evident in the quote from Dr. Goldenson above. Dr. Nelson, the Chief Medical Officer (CMO) of the migrant clinic in the Skagit Valley told me that the migrant workers who cross into the U.S. are "the stars" of Mexico. Johanna, the midwife in the same clinic, told me that they are "the best and the bravest" of Mexico because they are the ones successfully crossing the border and finding work in the U.S. Dr. McCaffree told me she was continually "amazed by how they keep going" and "seem happy and content" despite their difficult lots in life. Several clinicians told me that Mexican farm workers complain less than white patients about their sicknesses and use fewer public resources like clinic services, welfare, and worker's compensation. Multiple times, physicians and nurses told me that the Mexican migrants were more respectful and their children more well-behaved than the white patients in their clinic and that the Oaxacans (indigenous Triqui and Mixteco people from the Mexican State of Oaxaca) were especially respectful.

At the same time, several clinicians had complaints about their migrant patients. One nurse in the Skagit Valley told me, "they don't really take care of themselves." She explained that they need to be taught how to care for their bodies. Dr. Goldenson explained that Mexican migrants "don't think they need medicines." As an example, he told me that they often misunderstand the results of untreated diabetes and conclude that diabetes treatments, like insulin, cause the sequelae of the disease, such as blindness. Several physicians complained about the beliefs of Mexican patients in "culture-bound syndromes," like *susto* (see Rubel, 1960; Rubel & Moore, 2001), and in traditional healers (see Bade 2004; Romanucci-Ross 1969). Some clinicians blamed the poor health outcomes of their patients on these beliefs and behaviors. Johanna, the midwife at the Washington migrant clinic, dealt with these differences creatively, designing a prescription for *susto*. She explained that the cure involves chamomile tea and rest from household chores and that it has a high success rate. She went on to explain another difficulty working with Mexican migrant farm workers.

"One of the most interesting aspects working with Spanish-speaking patients is this real disinclination to want to be specific and quantify. It is just enormous. If you ask somebody, 'how long has this been bothering you? Or where does it hurt?' what you 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, 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 is just really hard to get a good history."

She continued that she thinks this problem relates to a lack of good health care in Mexico and a religious shame at sickness being related to personal sin or moral failing. During my observations in clinical encounters, however, it was not clear that Mexican migrant patients were any more likely to give vague answers than the poor, white local resident patients.

Most clinicians indicated that the primary health problems of migrant farm workers included diabetes, body pain from work, work-related injuries and dental problems. Dr. Nelson, the CMO of the migrant clinic in Washington State 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 such that the problems become serious and he often

had to extract the teeth. In addition, he explained that working with Mexican patients was difficult due to what he perceived to be ethnic body 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.”

The physicians in the migrant clinics told me that the common dental problems were due to giving too much juice in bottles to the children (c.f. Horton and Barker 2010).

Johanna, the midwife, described that she sees a lot of domestic violence perpetrated by the men against their wives. She explained her theory that this violence comes from Mexican men’s deep disappointment with unmet expectations in coming to the U.S. The nurses in the same clinic, however, told me there is very little domestic violence among migrant workers.

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 vague aches and pains in the women. All of the other clinicians told me that the migrant workers had lower rates of substance abuse, including alcoholism, than their U.S. citizen patients. Dr. McCaffree’s nurse explained that she sees a lower incidence of depression among the migrant patients than the white area resident patients.

Of note, there is often a misunderstanding about marriage between health professionals and their Triqui patients. The vast majority of Triqui people engage in traditional partnering practices, which involve the male paying a bridewealth to the family of their fiancée (Holmes, 2009). Most couples do not engage in a Church or state wedding. The legal status of this partnering, then, is complicated because the couples do not fill out governmental marriage forms, yet the Triqui indigenous group recognizes these traditional marriages. Thus, many of the “unwed pregnancies” cited by Dr. McCaffree are likely not so simply categorizable.

Beyond the misunderstanding of Triqui marriage, another intercultural and legal problem surrounding Triqui partnering relates to the ages of the couple. Triqui males routinely marry between the ages of 16 and 20, while their female partners are often between the ages of 14 and 18. According to Triqui people and migrant health clinicians in Washington State and California, the following scenario is a regular occurrence. A Triqui couple goes to the hospital for the wife to give birth to her first child. During the patient interview, the clinician utilizes specific definitions to determine that the couple is not legally married and then discover that the woman is under 17 years of age and the man is 17 years of age or older. The hospital staff then contact law enforcement agencies, the woman is placed in custody of a relative or the court, and the man is convicted of statutory rape. He is put in prison for up to ten years in some states (Quinones 1998, see Holmes, 2009). In the cases of the two Triqui couples I observed through their first child’s birth, the nursing staff chose not to report their ages, considering the story laid out above to be a cruel misunderstanding.

Dr. Nelson, the CMO of the clinic in Washington State, told me that “approximately 75%” 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 State because they know the public health plan is strong. On a similar note, several of the welfare agents in Madera, California, told me that there are signs “all over Oaxaca” telling people to go to Madera County because they can get welfare there. Over the course of my fieldwork, however, I never heard a single Mexican migrant mention welfare or health care as

a reason for their migration. In all my travels through Oaxaca, I never once saw a sign advertising welfare in the U.S., much less in Madera County, California. In fact, the vast majority of my Triqui companions did not qualify for Washington State’s health plan nor California’s welfare program because they move too frequently and because of their unauthorized status. Some Triqui families applied for and received basic short-term perinatal nutritional support, though this support proved to be minimal and the process very difficult and time-consuming to navigate.

Dr. Nelson explained to me that Mexican migrants 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 statement. Dr. Samuelson performs many of the Spanish-speaking independent medical exams for worker’s compensation in the area. He explained that the language barrier in many medical exams cause problems with testing the reliability of the patient. In addition, he stated that migrant patients have a different mindset about pain and “this is not allowed in worker’s compensation.” 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, I will go through the same exam and get completely different results. But the suspicions of malingering have already been raised.”

For the very few undocumented migrants who file worker’s compensation claims due to work injuries, this suspicion leads to problems in their files. Thus, Dr. Samuelson explained, it is often necessary for migrant patients to see multiple physicians in order to find one who might treat them with sensitivity.

The health professionals with whom I interacted often noticed differences between the Oaxacans and other Mexican migrant workers. Dr. McCaffree told me,

“They seem a lot poorer and they don’t have access [to health care]. Their clothes are a little bit dirtier. They tend to be a lot thinner and do not have much obesity and have clothes that don’t get changed a lot.”

On many occasions, clinicians told me that Oaxacans have worse health status than other groups. The nurse midwife, Johanna, told me, “they’re just sicker and have more body pains.”

Clinicians’ perceptions of their migrant patients are produced partially through brief clinical encounters, partially through related experiences in medical training, and partially through narratives read and heard in the popular media and in everyday public discourse. Sensational and sometimes contradictory narratives of “the migrant problem” circulate in public discourse and the media (see, e.g. Sassen, 1998 ch. 3, Grillo 1985; Bustamante, 1983; Quesada, 1999), necessarily informing the lenses through which clinicians understand their migrant patients. In medical school, future physicians are trained to focus on biological and behavioral inputs into health (c.f. Anspach 1988; Good, 1994; Holmes, 2011; Holmes & Ponte, 2011). Specifically, while interacting with poor, underserved patients, medical students are trained to consider individual and cultural factors and not social, economic, or political factors (c.f. Jenks, 2011; Rivkin-Fish, 2011). Given this individualized and bio-behaviorally reductionist training as well as the challenging and rushed circumstances in which biomedical professionals work, very little time is devoted to “the social history” in the medical encounter in the migrant clinic. This aspect of the clinical interview is most often limited solely to sexual and substance abuse risk behaviors with the occasional notation of language, occupation, and/or ethnicity. Only very rarely during my fieldwork did clinicians ask questions about the living or working

conditions of their migrant patients. Only one physician visited a migrant camp during my fieldwork, though most of the nurses in the migrant clinics have visited migrant labor camps as part of the clinics' health outreach fairs conducted.

Migrant patients' experiences of health care

As described in the Introduction, migrant farm workers, on multiple different occasions in different contexts, stated "*los medicos no saben nada*" (the doctors do not know anything). After each of these statements, I asked the migrant worker to explain further. In most cases, the migrant patient explained both structural obstacles as well as problems navigating through the perceptions and presumptions of their health care providers. Abelino explained simply, "they didn't do anything that helped me." In listening further to his experience of health care after his knee injury, much of the problem was structural – from rushed appointments to lack of translation – and some of it related to the perceptions of the clinicians – from assumptions about him bending his knees "incorrectly" to presumptions of ethnic bodily predispositions. Thus, the frustration of unauthorized Triqui migrants with physicians comes from both the structures of health care in the US and also from the medical gaze at work in the clinic.

Summary

Unauthorized indigenous Mexican migrants face many barriers to health care, including those found inside the clinic in their interactions with health care professionals. These obstacles include rushed schedules, power differentials, simple misunderstandings, and more complicated sociocultural assumptions and perceptions. The rushed schedules are but one of the many structural difficulties confronted by health professionals in the field of migrant health. Others described in this research include language barriers, unstable funding, patchy medical records, and the irregular work schedules of their patients.

Migrant health clinicians in Washington State and California perceive their Mexican migrant patients in varied ways. These physicians and nurses consider them to be respectful, tough, and deserving of quality health care. At the same time, they see the migrant workers as frustrating due to their "traditional" health beliefs and vague medical histories. Many clinicians make ethnocentric assumptions about these patients, for example, related to the reality of their marriages. Clinicians disagree regarding the prevalence of substance abuse and depression as well as the use or misuse of worker's compensation services. However, these health professionals largely converge in understanding the etiology of sicknesses – for example, dental problems – to be found in their patients' biology – bone structure like "granite" – or behavior – giving juice in bottles. Conversely, health professionals in this investigation tend not to see social, economic, or political factors in the etiology of sickness. Thus, the genesis of the patient's sickness is subtly located in the patient herself – her biology or her behavior. These rushed, confusing, and often subtly blaming interactions are part of the experience of medical care leading unauthorized migrants to conclude repeatedly that "*los médicos no saben nada*" (the doctors do not know anything).

Discussion

Structural and perceptual barriers in migrant health care

As pointed out in the Introduction, international political economic asymmetries produce conditions in which specific groups of people are forced to migrate and accept injurious living

and working conditions in order to survive (Holmes 2007). It has been argued elsewhere that these macro political economic and social forces – for example, labor camp and working conditions as well as international economic policies that concentrate wealth and expand poverty – are the most proximal causes of migrant sickness and suffering (Holmes 2006, 2007). Due to their location at the bottom of several hierarchies (c.f. Pombo & Dolores, 2006), the undocumented Triqui migrant workers endure more than their share of injury and sickness (Holmes 2007). The current research uncovers social structural as well as cultural barriers to health care for unauthorized indigenous Mexican migrants. The experiences of suffering and sickness of Triqui migrant farm workers 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 their Triqui patients. As the ethnographic data indicate, these perceptions go from positive to negative, subtle to explicit.

The importance of perception in social interactions cannot be overstated. Pierre Bourdieu states that, "being is being perceived" (1997, p.67). Stated in the converse, there is no being that is not bound up in perception. In other words, each person is defined by the perceptions of others. Simultaneously, we must remember that perception is not solely a cognitive, mental phenomenon. Perception necessarily involves also visceral, bodily sensations and reactions (*Ibid.*). Such mental and bodily perceptions determine people's actions toward another person, shape the possible actions of the other person herself, and – in this dialogic process – produce the material conditions in which she lives.

The Introduction briefly describes Foucault's clinical gaze as acontextual and reductionistic, focused on the organs and the body. Much of the social science of biomedicine follows Foucault, understanding the gaze primarily in this individualizing and biologically reductionistic manner (e.g. Davenport, 2000; Good, 1994). As Foucault's conception of the gaze would suggest, most of the clinicians described above see the individual migrant bodies in their offices, but do not consider the social context outside their offices. Yet, as pointed out by the ethnographic data, the clinical gaze in the field of migrant health is more complex and nuanced. While migrant health clinicians have not been trained to see the social determinants of their patients' suffering, most feel a strong calling to work with migrant populations and maintain idealism in the face of a very difficult situation. Indeed, it appears that this very mixture of acontextuality and idealism constitutes the clinical gaze in the field of migrant health.

Most of these clinicians have chosen their positions, feeling compassion and a desire to help underserved populations. Yet, the lenses they are offered in medical training have been narrowly-focused, individualistic, and asocial. By and large, physicians in the U.S. are not trained to see the social determinants of health problems, nor to hear these factors when communicated by their patients (Holmes 2006; Holmes & Ponte, 2011). This acontextuality is seen when charted social histories include only risk behaviors and health problems are blamed on cultural customs. Beyond Foucault's clinical gaze, physicians today are taught to see risk behaviors in health—such as diet, sexual behaviors, and substance abuse (see Holmes 2007). Behavioral health education is the primary outcome of the progressive move toward biopsychosocial medical education described first by George Engel (1977). However, the lenses of individual biology and individual risk behavior remain limited, excluding the political economic structures and institutional prejudices that shape much of sickness and health. Thus, well-meaning and well-trained clinicians may inadvertently blame the patient – their biology or behavior – for their suffering. Even those clinicians aware of the social determinants of sickness may

resort to biological and behavioral explanations as a defense mechanism against what they experience as hopeless. Thus, the victim of social inequalities is blamed for her poor health and the social inequalities themselves are left unexamined and unchallenged. The most proximal determinants of sickness are left unseen and unchallenged such that biomedicine functions as a subtle and effective “anti-politics machine” (c.f. Ferguson 1990). These experiences of subtle blame and lack of acknowledgment of the effects of sociopolitical, realities foster the experience of migrant laborers that “*los médicos no saben nada*” (the doctors do not know anything).

At the same time, this ethnography of the practice of migrant health shows an idealism inherent to the gaze. Some of this idealism appears to be suppressed by the difficult circumstances in which clinicians work and contradicted by negative stereotypes of migrant patients. However, the ethnographic data show instances of medical providers acknowledging the humanity and occasion, analyzing the social context of their patients. Specifically, Dr. Samuelson pays attention to the responses of his migrant patients to worker’s compensation claims exams instead of applying an ethnocentric presumptive analysis. Similarly, the hospital obstetric nurses appear to step out of their received understandings of marriage in the U.S. and show solidarity with their patients who are indigenous Mexican, young, new mothers. These instances help us imagine alternative models for interactions and perceptions in the migrant clinic.

Implications

A multi-faceted approach will be necessary to ameliorate the barriers in the clinician-migrant patient relationship. First, clinicians must move beyond an acontextual clinical gaze by acknowledging and considering the social determinants of sickness and health (Davenport, 2000; Scheper-Hughes 1994; Smith & Hilsbos, 1999). This will not only increase rapport with unauthorized migrant patients who often feel intensely the effects of such structural forces but also allow for more realistic diagnoses and interventions. This will require taking seriously the social history, moving beyond risk behaviors to listen to migrant patients about their occupational history, living conditions, language proficiency, and other important social factors and stressors.

In order to broaden the clinical gaze to include social context, health professional schools and continuing medical education must take seriously the need for training in social analysis (Farmer 1992; Henderson et al., 1997; Holmes 2006; Kleinman et al., 1995, 1997; Virchow & Rather, 1985). Without the addition of social analysis in medical education, trainees are left with only biological and behavioral lenses through which to understand their patients’ suffering. Adding social context will allow for more respectful and effective multicultural healthcare than that proposed by most cultural competency training (Hester 2009; Willen et al., 2010; Jenks, 2011). Mainstream cultural competency training often assumes the culture of the patient as the problem that needs to be understood and the barrier that can and should be overcome. However, the ethnographic and interview data above contradict this focus by showing that it is often the structure and the culture of biomedicine that functions as a barrier to effective care. Medical educators might do better to exchange mainstream cultural competency for training in “structural competency” (Metzl 2010, p.203). After all, the social determinants of sickness are a matter of life and death.

Finally, policymakers and clinicians must take seriously the restructuring of health and immigration policies. Not only are unauthorized migrant laborers exceptionally vulnerable to the social determinants of suffering, but they also have extremely poor

access to health care (Chavez 1992; Quesada, 1999; Rothenberg 1998; Zabin et al., 1993). Health care access must be strengthened for this structurally vulnerable population. This will require funding migrant health care, re-structuring clinic schedules and outreach programs to match the work schedules of most migrants, and expanding translation services. The “right to health” framework (Willen ad Mulligan, 2011) must be expanded to involve the larger political economic context and not simply the distribution of health care. Specifically, the macro level political economic determinants of suffering must be counteracted by humane domestic and border policies (Arizona Daily Star 2005; INS 1998). Global economic policies, such as NAFTA and CAFTA, must be re-negotiated to curb the need for dangerous labor migration to survive (c.f. Burawoy, 1976). Only through these educational and policy interventions, can we show active solidarity with this structurally vulnerable population and avoid giving the impression that the doctors and the health care system “don’t know anything.”

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