New healthcare system regulations, same problems

A Study on the Effects of Unattainable Healthcare and a Non-Government Funded Organization in New York City

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2016

MASTERUPPSATSER I KULTURANTROPOLOGI
Nr 64
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ABSTRACT: NEW HEALTHCARE SYSTEM REGULATIONS, SAME PROBLEMS: A Study on the Effects of Unaffordable Health Insurance and a Non-Government Funded Organization in New York City

Throughout the existence of the United States there have been multiple ways to seek healthcare insurance, and healthcare services and treatment. As the country developed a system in which healthcare was distributed was created. As such, this system has created societal divisions and has caused certain people to be excluded from gaining access to healthcare insurance and treatment. From these divisions, certain stigmas and stereotypes have been created about the type of person that does not have access to healthcare. With certain historical reforms in the U.S. healthcare system being currently implemented, the healthcare system is to change dramatically. However, certain people are still being excluded from gaining access to healthcare insurance and healthcare services.

The following thesis, based on research which was conducted from April to July 2014 in the Brooklyn borough of New York City, explores the manner in which recent developments and changes within the healthcare system of the United States inhibits the city’s residents from obtaining basic health care. By focusing on medical encounters, this thesis focuses on how agencies of power retain control of the body, and those that seek access to healthcare. This thesis also explores the opinion of the uninsured patients by those who volunteer at The Coalition of Concerned Medical Professionals, which is an organization that offers free healthcare services while acting as political advocates.

KEY WORDS: biopower, volunteers, uninsured patients, stigmas, United States Healthcare System, medical anthropology
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<tr>
<th>Acronym</th>
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<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
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<td>AMA</td>
<td>American Medical Association</td>
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<td>CCMP</td>
<td>Coalition of Concerned Medical Professionals</td>
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<td>CDC</td>
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<td>DRGs</td>
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<td>Health Maintenance Organization</td>
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<td>OLGFC</td>
<td>Our Lady Guadalupe Free Clinic</td>
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<td>RCHD</td>
<td>Riverhead County Health Department</td>
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ACKNOWLEDGEMENTS:

First and foremost, I would like to thank my supervisor Gabriella Körling for her guidance and her patience in my journey to complete this thesis. I am immensely grateful for her constructive comments, and her inspiring words which drove me to create this particular work.

A special thanks to Elizabeth Stevens for sharing her tales, her experiences, and her overall optimistic look on life with me. Thanks to Luz Figueroa for showing me the ropes at the Coalition of Concerned Medical Professionals (CCMP). I have the highest amount of gratitude for these two inspiring women and all that they have given me, and all that they continue to do on a daily basis.

I would also like to thank the other volunteers at the CCMP; from the doctors that have dedicated their free time to saving the lives of uninsured patients, to the volunteers that have lent a hand whenever and wherever they could.

A special thanks to the patients at the CCMP for sharing their stories with me, along with all their fears, and all their hopes.

I would like to thank my many classmates and instructors within the Cultural Anthropology Master’s Program for sharing their thoughts, and their wisdom of multiple subjects over the course of these two years. Many thanks to Caitlyn McEvoy for being my writing partner during this stressful, yet interesting, time and for providing much amusement along the way. I also thank Adelaida Caballero for her wise words and encouragement.

A final, but immense thank you to my family and friends who supported me during this project and life altering time of my master’s studies. Especially that of my mother who has always supported me.

Chapter One: An Introduction

In the United States there are multiple ways of obtaining healthcare services and treatment. However those services and treatments are mainly accessed through healthcare insurance. One can either obtain healthcare insurance and its services via an employer, or one can buy a private insurance plan. Of course there are people that cannot obtain healthcare insurance or its services through their employer. There are also people that cannot afford to buy healthcare insurance otherwise. As the healthcare services sector in the U.S. has become a commodity in which private businesses invest billions of dollars each year hoping to gain the largest profits possible, the healthcare system inhibits certain types of people from getting insurance. This difficulty of obtaining insurance therefore restricts access to healthcare services and treatment. However there are other ways of obtaining healthcare services and treatment, either through free healthcare clinics or other programs and organizations that administer aid. The Coalition of Concerned Medical Professionals (CCMP) is an example of such an organization.

The CCMP not only acts as a political advocate that fights for a comprehensive healthcare system for all, but also as a preventative program that offers free healthcare aid and treatment. This organization, which was originally established in New York City in the late 1970s, also has a small sister site in Oakland, California and hopes to one day build their very own hospital. The CCMP also offers legal aid to patients that may need help with any judicial hearings and other dealings with healthcare insurance providers, or any other healthcare issues that may need legal action. Although the CCMP offers certain healthcare services during particular times, they are adamant that they are not a free healthcare clinic. The CCMP was my field site for over fifteen weeks and it was at this organization that I encountered many people,
and gathered the data on which this thesis is based. It was also at this organization that I would begin to utilize methods that I had only previously studied, encounter hardships, face internal conflicts, and question my studies.

A Glimpse into the Overwhelmed Graduate Student

As the three volunteers of the CCMP walked through the door of the organization’s Brooklyn location a feeling of tiredness overwhelmed me. The Brooklyn location of the Coalition of Concerned Medical Professionals is located within the Canarsie neighborhood of the borough. The two-floored building was originally a family home that was converted into a small clinic-of sorts, and still has an apartment on the top floor. The basement has flooded multiple times, and there are many leaks that occur in the kitchen and in the reception room when it rains. The building has recently had a new boiler installed, as well as a new roof, but is in desperate need of new windows. As it was currently a rainy day, buckets were placed in strategic places throughout the CCMP building.

The falling rain drops echoed throughout the room as they made their way into the buckets and the three volunteers all began to go their separate ways within the building. Beth, the President of the CCMP’s Brooklyn location, went to the office area in the reception room and began to check if there were any messages left on the answering machine. Luz, the Operations Manager, began putting away the materials that she had brought along with us to a speaking engagement. And I, a lonely anthropology student simultaneously conducting my internship while gathering more data, wandered around and wondered what I should do. I finally decided to settle down and sat on a chair in the reception area.

Feeling incredibly tired from the day’s events, I closed my eyes and tried to take a short break. The sounds resulting from Luz and Beth continuing their activities provided a soundtrack as my eyes remained shut. I listened to Luz walk across the first floor as she put away supplies and listened to Beth playback messages. I also heard their chatter about the tasks that would have to completed the next day. As I felt myself begin to doze off, I suddenly heard a message
playback on the answering machine that grabbed my attention. From the muted voices that I could hear from the message on the answering machine, a few words in particular stood out to me. Those words included: “has unfortunately passed away” and “funeral arrangements are being made”. My eyes slowly opened and my sight came into focus. Once my vision had cleared I saw Luz and Beth share a look of sadness. An uninsured patient that they had been attempting to procure the proper medical attention for had died. Unsure of what I was to do, I kept quiet as I remained seated and watched the two women as they began to talk. In hushed tones Luz and Beth started to speak about seeing the family of the recently deceased, as well as figuring out what they could do to help the family in this time of grief.

As I released a heavy sigh, I began to question my presence there. I also questioned my work entirely; I had merely wanted to complete my fieldwork. While I questioned my work I began to wish that I had focused on a different field. I was an anthropology student and was suddenly in a field that was surrounded by death and suffering. I realized that I had not been properly prepared beforehand to enter such a setting as this. I motioned to Luz and Beth that I would be leaving as I knew that I could not be any help to them. As I closed the door behind me, I began to think of all the medical encounters that I had witnessed prior to this moment. I thought upon the interactions that I had witnessed between doctors and patients, I also thought about the way patients would speak about how difficult it was to get healthcare insurance, or how expensive treatments were. I also thought about how the current U.S. healthcare system created hardships for certain people to receive help. With that in mind, I set out to write a study that would shed light about some of their difficulties.

**Purpose and Aim**

In this thesis I explore the medical encounters between doctors, patients, and volunteers at the Coalition of Concerned Medical Professionals. The overall objective of this thesis is to understand the perception that volunteers (i.e. physicians and the multiple other types of volunteers at the organization) in such a setting like the CCMP have of uninsured patients. To be
more precise, when speaking of a setting like that of the CCMP, this relates to the fact that while the CCMP can be characterized as having a clinic-like environments of sorts, it remains an organization that has multiple aspects. As they are continuously incorrectly categorized as a free-clinic, the CCMP is adamant about their choice not to identify as a free healthcare clinic, as to be able to be rid of certain regulations that a free-clinic would have to abide by. The CCMP also has multiple steps and volunteers involved in the treatment of a patient, does not limit the amount of patients that can be seen during a medical session, and does not limit the amount of time a doctor may spend with a patient while conducting an exam; these are just some of the differences that set the CCMP apart from a free-clinic. From this, I secondarily question the manner in which the volunteering physicians treat the uninsured patients: Do the doctors treat the uninsured patients of the CCMP differently? Do they treat them with the same respect and regards as they would a patient with healthcare insurance? I also focus on some internal struggles that volunteers of the CCMP have in regards to their participation in the organization.

I focus on uninsured patients as societal notions within the U.S., such as the argument that healthcare is a privilege and not a universal human right\(^1\) nor should it be, have created certain perceptions about uninsured patients. Rules and regulations within the U.S. healthcare system have made it so that only certain U.S. residents are eligible for, or can afford, healthcare insurance. This causes social divisions that create social stigmas and stereotypes, of uninsured patients. Examples of this include the notion that they should not be helped because they do not deserve public support (Tiedje and Plevak 2014, 2), are undeserving, lazy and in search of a free handout, or are a second class citizen (Rivkin-Fish 2011, 198).

In this thesis I argue that agencies of power (e.g. insurance providers and private businesses/corporations in the healthcare services) retain control over people seeking, and already in the possession of, healthcare insurance and services via \textit{biopower}. Institutions of

\(^1\) The “right to health” for all persons regardless of color, gender, creed, or documentation status, was first articulated in the 1946 World Health Organization Constitution and recognized as a human right in the 1966 International Covenant on Economic, Social and Cultural Rights. The United Nations (UN) Committee on Economic and Social Rights specifies that “[S]tates are under the obligation to respect the right to health … refraining from denying or limiting equal access for all persons, including detainees, minorities, asylum seekers and illegal migrants, to preventive, curative, and palliative health services (Tiedje and Plevak, 2014: 2-3).
power have used the *punishment of the body* to maintain control of their profitable commodity (i.e. healthcare), and will go through drastic measures to keep it. When speaking of the *punishment of the body*, I refer to the act of withholding certain healthcare services and treatment that in turn have a physical effect on the person seeking aid. As a result of the use of biopower by agencies, social stigmas and stereotypes of uninsured patients are reproduced.

I argue that doctors, patients, and volunteers in the CCMP can be analyzed as a particular *medical field* situated in the context of the larger U.S. healthcare system. In this particular field these actors either accept certain popularized opinions (*doxa*) and social stigmas of the uninsured patient that have been created in part by agencies of power, or reject the social stigmas and stereotypes of the uninsured patient and form their own opinion (*orthodoxy*) of uninsured patients.

As the relationship between a doctor and patient is an important facet in the overall medical experience, this research will shed light on the encounters that occur within the examination room and beyond. This thesis will also continually question if the doctors themselves are an obstacle in the treatment of uninsured patients as they navigate a medical system that is dominated by economic interests.

**Medical Anthropology and its Current Debates**

Within *anthropology* many subfields have developed over the years. However, one subfield that has grown to not only include the cultural, the biological, and the psychological is that of medical anthropology.

Medical Anthropology is in a continual state of reconstruction and it takes on various forms in countries all over the world. Medical anthropology and its research, which spans the globe from epidemics within a specific town in the U.S. to ritualistic healing within African cultures, is currently being used to aid public health by showing how an “anthropological approach can contribute to both a better understanding of health and illness to more culturally compatible health measures” (Geissler and Pool 2005, 1). However, at the fundamental core of
medical anthropology remains such facets as culture, race, epidemiology, advancements in treatment, wellbeing, and kinship relations that are formed between doctors and patients.

Currently there are various debates within medical anthropology about the knowledge and definition of sickness/illness, health and healing. There are also debates about economic influences upon health and healthcare. Of course there are also debates about conceptions of the body and conceptions of the psychological self. Many debates within medical anthropology also deal with the conceptions of ritualistic, or spiritual, methods of healing in contrast to the healing and treatment methods that are normalized in civilizations located on the western hemisphere and in large parts of Europe. The role of technology in the treatment of a patient is also debated.

In this thesis I draw upon work in medical anthropology that focuses on public health. For instance, medical anthropologists have been working to inform international organizations about the traditional and ritualistic practices of the world since the 1950s (Geisser and Pool 2005, 30). Medical anthropologists have also aided health professionals by analyzing and researching certain treatments and programs (Geisser and Pool 2005, 30). Of course a research theme that is continuous within medical anthropology is the doctor-patient relationship and what such relations contain. Other debates that relate to the doctor-patient interaction question the necessity of empathy in the doctor-patient relationship (Fainzang 2007, 2) as well as the continual problematic structure of the doctor-patient relationship in the Western hemisphere, which is riddled with patient dissatisfaction and poor communication (Lazarus 1988, 34).

Research on the doctor-patient relationship that closely relate to my thesis consist of the doctor-patient relationship that exist in settings where doctors provide free healthcare services. In Tiedje and Plevak’s 2014 article Medical Humanitarianism in the United States: Alternative Healthcare, Spirituality and Political Advocacy in the Case of Our Lady Guadalupe Free Clinic, the authors comment upon how the U.S. healthcare system excludes undocumented migrants (predominantly Latin immigrants) from receiving healthcare insurance and services. The role of the current U.S. healthcare system is a theme that can be found in my thesis as well. The authors speak about the way volunteering doctors at the Our Lady of Guadalupe Free Clinic deal with undocumented, uninsured patients. This article shows how volunteers, with multiple reasons for
volunteering which include wishing to service the unfortunate and religious motivations, interact with the uninsured patients that they are treating with the same amount of integrity and respect as any other patient they would come into contact with. Another aspect that relates to my work within Tiedje and Plevak’s work is the notion of healthcare as a universal human right, and the opinion of those that do not have access to healthcare by the volunteers that closely work with them.

In the article Witnessing and the Medical Gaze: How Medical Students Learn to See at a Free Clinic for the Homeless, Davenport illustrates how communication between doctors and patients is integral when dealing with a patient. The observed current communication that takes place in the doctor-patient relationship is one that is influenced by the notion of perceiving the patient as an object. The objectification of the patient, which also relates to my thesis, is related to medical students during their education. They are told to view the patient as a problematic body part rather than a human being (Davenport 2000, 311). The objectification of the patient turns problematic when volunteering, as volunteering doctors are asked to reserve judgement when treating patients and focus on delivering quality treatment.

In Deadly Inequality in the Health Care “Safety Net”: Uninsured Ethnic Minorities’ Struggle to Live with Life-Threatening Illnesses Gay Becker describes the difficulties many people face when seeking healthcare, while critiquing the failures of such care. The article shows that the uninsured are more likely to suffer from ailments and feelings of being discriminated against. It also points to the different ways in which uninsured patients are deemed to be the “other” (Becker 2004, 259). The categorization of the uninsured patient into something that is against the norm, or lesser than the majority of the larger group in the social structure is an aspect that I also address in my thesis.

Michele Rivkin-Fish’s article Learning the Moral Economy of Commodified Health Care: “Community Education,” Failed Consumers and the Shaping of Ethical Clinician-Citizens is another work that I will draw upon in this thesis. In Rivkin-Fish’s article, the concept of re-affirming negative stereotypes about patients that cannot afford healthcare services is brought up (Rivkin-Fish 2011, 185). The article describes how volunteering physicians perceive the poor
patients that they treat as somehow being ungrateful, unreliable, and unappreciative compared to the patients that they may encounter in a private practice (Rivkin-Fish 2011, 192-193).

**Foucault and His Works**

Over the years Michel Foucault has created and developed a number of theoretical concepts that have lent themselves to the analysis of multiple issues within the various fields of academia. Among such concepts is that of *biopower*. Biopower is first introduced by Foucault in his work *The History of Sexuality Volume 1*. Foucault is very descriptive in his efforts to accurately portray different notions of power within his work. Foucault states that the 18th century saw the manifestation of practices. At this time it was within the Sovereign's power and right to either allow people to continue going on with their lives or take away the means and right for them to continue to live (Foucault 2004, 241). From the progression of the sovereign state into that of the modern nation state, biopower can be described as the manner in which a modern nation state continually maintains power over its inhabitants while being sure to “make live and let die” (Foucault 1990, 135). Essentially biopower is having control and power over bodies. Foucault writes that it is an “an explosion of numerous and diverse techniques for achieving the subjugations of bodies and the control of populations” (Foucault 1988, 140). It is a method in which a society or other institution of power may manage a large group of people.

In his lectures on biopower called *Security, Territory, Population*, Foucault later develops the notion of biopower and what it entails. Foucault states that when he uses the term biopower he is speaking of how what once was a mere, simple biological feature of the human species has been altered by strategies that relate to politics and power within Western societies (Foucault 2007, 1).

In the modern day, certain sovereignties continue to utilize biopower via the form of biopolitics in multiple ways. One such sovereignty is that of the United States. As the healthcare

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2 The power over a subject’s life, or essentially the power over life and death is emergent in two forms according to Foucault. The disciplinary technique of power that emerged during the 17th century that focused upon the individual body, and that of the technology of power that developed within the 18th century. The power of technology that
system is now a commodity, policies have given certain corporations in the healthcare sector the power to utilize various forms of bodily punishment (i.e. causing bodily punishment by inhibiting people seeking healthcare services and treatment if they are unable to pay a large price for said services and treatments) in order to maintain control over the populations that reside within the country. The concept of biopower will be utilized in my thesis in multiple ways. When gathering data at the CCMP I witnessed agencies of power (i.e. insurance companies and other businesses in the healthcare sector) utilize rules and regulations to manipulate the body, of not only those who did manage to have healthcare insurance but those who would try and obtain healthcare insurance. I will use biopower to show how these agencies of power subjugate and control bodies. I will also use biopower to show how biological features are related to political policies in the United States. Some examples, which will be explained in greater detail later on in this thesis, include: insurance agencies inhibiting a consulting doctor from making certain diagnoses, insurance agencies unwilling to pay for therapy treatment but willing to pay for amputation, and insurance agencies restricting the time a doctor can spend examining a patient.

**Bourdieu and His Works**

As progressive strides are being made within the field of anthropology, founding theories are continually being re-formulated in an effort to interpret and explain contemporary matters. Even founding theories, such as structuralism, have been re-imagined. Such theories stemming from the classics of structuralism include post-structuralist Pierre Bourdieu’s theory of practice. Within the theoretical work of Pierre Bourdieu, *Outline of a Theory of Practice*, his empirical data consists of the findings of his interactions with the Kabylia of Algeria. Bourdieu, being influenced by the likes of Blaise Pascal, Marcel Mauss, and Émile Durkheim, hails from the structuralist school of thought. Bourdieu draws upon the works of Levi-Strauss and has interests in the basics of human social organization, as well as gaining an understanding of the complex developed during the 18th century pertained more to the dissolvement of a mass into individual bodies (Foucault, 2004, 242). From these progressions, governments and sovereignties now focus on controlling and regulating the lives of the population. As such, this new source of power which controls the population is termed as biopolitics.
interconnected social relationships between a subject and a society (Samuelsen and Steffen 2004, 5).

In an effort to unite phenomenological knowledge with the objectivist knowledge, Bourdieu developed his own post-structuralist notion of practice theory. This practice theory is set against the aspect that social life may be understood via an application of set rules (Bourdieu 1977, 16). In creating his own theory of practice, Bourdieu created the notion of the field, the doxa, and the orthodoxy.

To understand the notion of the field, one must first understand the habitus. Bourdieu writes that it is an active social environment that promotes and prompts cultural production. This cognitive structure is created through everyday interaction and activities. The transposable dispositions that constitute the habitus “arise in an environment of everyday practical activities” (Moore and Sanders 2006, 327). As such, interests, values, and ways of life are created. Bourdieu writes that the field is a specific space of relations in which individuals and institutions are placed (Samuelsen and Steffen 2004, 5). Though there are multiple ways in which to characterize a field, i.e. field of power, field of religion (Samuelsen and Steffen 2004, 5), field of medicine etc., individuals and institutions are positioned in a field based on their habitus.

As for the doxa, the common constructed belief and popular opinion, it is here that limitations on social mobility are set by the dominant classes. The naturalized limitations and common sense (Bourdieu 1997, 64) which adhere to the mental and social structure is categorized as the doxa. These fundamental, learned and unconscious beliefs, and values are taken as self-evident, essential (Bourdieu 1977, 167).

Bourdieu also presents the notion of the orthodoxy, the “necessarily imperfect substitute” (Bourdieu 1977, 169). The orthodoxy, or “straightened opinion” (Bourdieu 1977, 169), is a prompted response to the challenge of the doxa that appears when the dominated classes have either the material or cognitive means to reject the imposing logic that reproduce the social structures they inhabit (Bourdieu 1977, 169).

This thesis will utilize the notions of Foucault to show the medical field in the setting of the CCMP. By understanding the actors in the CCMP I will seek to understand the social
structural power relations, as well as the practices and general patterns of thought that create and reproduce social inequality (Bourgois and Schonberg 2007, 9). I will also explore the doxa of those that volunteer at the CCMP.

In brief, the works of Foucault and Bourdieu will add to the understanding of healthcare practices in the CCMP setting. Concepts developed by the two scholars will show how certain societal structures influence the individual, and how power works on various levels within social interactions (Samuelsen and Steffen 2004, 3).

An Outline

Below is a short and comprehensive description of what the remaining chapters in the thesis consist of. There are eight chapters that compile this thesis.

Chapter 2 consists of the methodology through which I went about collecting the data used to create this thesis. The processes that I used to gather information are also described in the chapter as well as the way in which I went about finding, creating, and entering the field. I also highlight a methodological realization and shift that occurred during my fieldwork, as well as certain personal conflicts that I faced while in the field.

Chapter 3 provides the reader with the background of particular points that are essential in the ethnographic chapters. It is in this chapter that the history of the United States healthcare system, as well as the construction of the healthcare insurance system, is described from its beginnings. This chapter also includes the current integration of the Affordable Care Act (ACA) into the U.S. healthcare system. The third chapter within my thesis also serves as a brief breakdown of what the ACA is composed of, as well as the current dominance of the private sector in healthcare.

Chapters 4, 5, 6 and 7 are the ethnographic chapters that compose my thesis. The interconnected ethnographic chapters explore the multiple components of the organization the
Coalition of Concerned Medical Professionals. The ethnographic chapters are based on the empirical data that was gathered during fieldwork and the completion of an internship.

Chapter 4 is entitled *A History of Struggle* and describes the basic structure of what the Coalition of Concerned Medical Professionals stands for. This ethnographic chapter reiterates the reasons as to why the CCMP currently acts as a grassroots organization that refuses to accept government funding, as well as how the organization not only offers free healthcare services but acts as political advocates for universal healthcare. The history of the organization, from its creation in the year 1973 until current times, are recalled within the chapter. *A History of Struggle* also sheds light on the lives of the only two current twenty-four/seven volunteers that reside above the CCMP offices, Elizabeth Stevens and Luz Figueroa.

Chapter 5, *The Wall Street Businessman and the Undocumented Migrant*, depicts the various patients that walked through the doors of the CCMP. When first entering the organization I assumed that I would be dealing with a specific type of patient. This chapter shares the anecdotes of the multiple patients that were associated with the organization. This chapter also shows that the patients at the CCMP came from very different backgrounds that challenge the common stereotypes of who would be dependent on free healthcare, and that the common denominator is that they all lack health insurance and therefore healthcare treatment.

Chapter 6 labeled *The Volunteer and the Patient* is a chapter that shares descriptions of the various volunteers at the CCMP that act as advocates. This specific chapter describes the work of ‘advocacy’ along with sharing the personal history of a patient that I acted as an advocate for. The chapter also explores the perception of the uninsured patient by the volunteers.

Chapter 7, called *A Doctor and Their Patient*, serves as a series of snapshot of sorts by briefly describing the multiple doctors that were encountered during my time at the CCMP, as well as anecdotes of doctors that other volunteers have dealt with during their time at the organization. The chapter also serves as a basis for exploring the multiple perceptions and relations that a physician may have with a patient.

Chapter 8 synthesizes the thesis and finishes by reiterating the main research focuses and aims, before making the final conclusions.
Chapter Two: Methods of New and Old

“... What happens when social science tries to describe things that are complex, diffuse and messy. The answer is ... that it tends to make a mess of it.” (Law 2004, 2)

This thesis is based on data collected over five weeks of fieldwork conducted from April to May 2014 at the Coalition of Concerned Medical Professionals’ (CCMP) Brooklyn location. I was also able to collect additional data during an internship, which also acted as an extension of my fieldwork, which was completed at the same site from May to July 2014. I was incredibly lucky to have conducted my internship at the same field site as it provided me with further time to collect data. As a result of this I was able to make further observations and analysis, as well as conduct more interviews with patients and volunteers. If I had completed my internship at another organization I may have not been privy to the additional information. In this chapter particular methods that were used during fieldwork are explained. These methods include the taking of photographs, participant observation, semi-structured and unstructured interviews with volunteers and patients, and the use of questionnaires. Current methodological issues are also highlighted within this chapter in terms of the role of the researcher within a hospital or clinical setting and certain limitations that are faced.

Finding, Creating and Entering the Field

My first encounter with the Coalition of Concerned Medical Professionals took place while I was completing my Bachelor’s degree at Hunter College in New York City. While attending a class two volunteers from the CCMP made a presentation about what it is that the CCMP stands for, what they do on a daily basis, and how every student within the classroom could make a difference. Intrigued by their presentation, and the passionate way in which they talked about their organization, I decided that I would volunteer. I gave the CCMP volunteers my contact information and told them that I was interested in helping in any way that I could. Once I
had contacted the organization, it was agreed upon that I would visit the CCMP location in
Brooklyn and learn more about the organization, its origins, and my potential role within the
organization.

During my first visit at the New York City headquarters, which consisted of an office
situated above an optometrist's office in Borough Park, Brooklyn, I was given a brief overview
of the organization’s beginnings and was then taken out on a “supply run” with another
volunteer. This “supply run” consisted of picking up donations from businesses within the
community. During this car ride the volunteer that went by the name of “Middie” kept going on
about the injustices that occurred in the healthcare system on a daily basis. Old in age, short and
wearing round wire-rimmed glasses that seemed far too big for her face, Middie continued to talk
about all the ways that people could be preventing the injustices that happen and potentially save
lives. Unfortunately, I was in my senior year of my bachelor’s studies and could not continue
volunteering with the CCMP due to time constraints.

However as the time neared for me to choose a thesis topic and decide upon the research
that I would carry out, the field of medical anthropology and the CCMP came to mind. With my
thesis proposal in place, I once again reached out to the CCMP and within days an agreement
had been made. I would conduct my fieldwork and internship at the organization that I had
encountered a few years before.

Prior to entering my field site I researched the surrounding neighborhood and collected
specific statistics. At first I anticipated that this data could somehow aid me with the aim of my
study. These statistics showed the economic status of the neighborhood’s inhabitants, as well as
the majority race of those living in the surrounding area. I initially thought that I would collect
data that would possibly help me in finding a certain correlation within these statistics, which
stated that a certain number of uninsured New York City inhabitants belong to a specific racial
category. However, at the end of my fieldwork I realized that these statistics were irrelevant to
my study. At the end of my time at the CCMP I had witnessed that the patients of the CCMP
came from various backgrounds, economic statuses, races and ages.
I also went into the field with certain data already collected and certain knowledge obtained, only to be faced with the reality that “what happens when the ethnographer ‘reaches’ the field can be equally mysterious, in part because the site and its boundaries may actually be determined post hoc through processes of analysis and writing” (Coleman and Collins 2006, 6). The site that I had constructed in my mind prior to fieldwork was vastly different to the site that I had encountered, and determined, during the writing of this thesis and during analysis. The reason for this mistake is largely due to the statistics that I had gathered beforehand. I incorrectly assumed that the field site I entered would correlate to every detail of the previously collected data concerning the patients that would be without healthcare insurance or access to treatment, and therefore be seeking help from the CCMP. From this I assumed that the field site would in some way be catered to those patients, therefore shaping and forming the field site, i.e. I assumed the CCMP would continually be in the act of helping a patient of a certain race, economic, or legal status. I assumed I would be hearing and speaking certain languages more than others, be in contact with certain genders more than others, be in contact with certain races more than others, or be in contact with those that belonged in a certain socio-economic class. As the CCMP attracts patients from all over New York City via word-of-mouth, recommendations from current and prior patients or volunteers, and the multiple literature tables that the volunteers conduct all throughout the five boroughs, it changed my perception of the CCMP. I began to think of the CCMP as an organization that helps every patient from all backgrounds to the best of their ability, while also acting as political advocates in the fight for comprehensive healthcare.

When first arriving at the Coalition of Concerned Medical Professionals site in Canarsie, Brooklyn, the first thing I took notice of was the surrounding neighborhood. Previous research claimed that this neighborhood was a working/middle class area. The area in which the CCMP lies is primarily residential and there is a school close by, but the houses and other building

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3 *CCMP Literature Tables* consist of CCMP volunteers taking certain documents (which describe the type of organization the CCMP is, its history, its activities and events) and a small portable table to a certain location. This location can be a street corner, a spot outside a building, or even an area at another event or activity. The purpose of literature tables is to not only spread the word about the CCMP, but to potentially recruit new volunteers and doctors. While conducting a literature table, CCMP volunteers also aim to raise donations. The CCMP aims to conduct approximately two literature tables a week.
facades look weary. One of those weary facades belongs to the Coalition of Concerned Medical Professionals, which lies in a converted two-floor residential building. While the top-floor remains an apartment, the lower-floor is now a small doctor's office of sorts.

Upon entering the CCMP the first person that greets me is Middie and I immediately remember our first meeting all those years ago as I follow her inside. Appearing to be a regular clinic, or as regular as a clinic within a residential building can be, there are a few chairs in the waiting room as the TV plays a mindless program. Middie is a woman in her sixties, perhaps even older and the first thing I notice is the slight curve to her upper back and the bump that looks to be forming. As she retreats behind the counter, she asks me general questions such as where I’ve gone to school, what I am majoring in, etc. It seems that the talkative older woman does not remember me and our first meeting all those years ago. Once more she begins to speak of all the problems in the U.S. healthcare system, and says that doctors should have a fixed salary that is separate from all the worries of insurance and malpractice. Middie also thinks that education should be free, and says that one of the doctors that works with CCMP would not recommend students going into the healthcare profession because of the current “climate”.

Once Middie finished talking Luz, the operations manager, greeted me and informed me that I was only the first volunteer to show up. Luz also told me that she was expecting several more volunteers to arrive that day. As Luz and I sat down a volunteer (who spoke very little English) was very adamant that he was sorry that he could not stay and help out, but was called in for work and could not deny the opportunity to make additional money. Luz would later tell me that the volunteer that I had met only moments ago had previously been, and still was, a patient. However after being treated by the CCMP he decided that he would like to give back to the organization in any way possible. He became a volunteer and helped whenever he could. Luz would also inform me that he was an undocumented immigrant who was afraid to ask for healthcare from the dangerous job that he worked for, and so he came to the CCMP. I would also later be informed that his job consisted of working with toxins in a locked room that was affecting his health.
As we waited for the other volunteers to show up Luz quickly gave me a tour of the lower floor. The lower floor consisted of a waiting room and reception area, a break room, an editing room which consisted of a small table, a few chairs and an outdated computer in which the seasonal newsletters were created, and a small but functional patient’s room where the exams would take place on a monthly basis. Luz also explained that everything within the office of the CCMP was donated. She would also explain that approximately 100 people a week must be contacted via telephone, met during talks at classes or during a literature table, or recruited. These people consisted of both old and potentially new volunteers to come in and help in any way that they could, as well as physicians that could donate either their time or their resources. She also spoke of the desperate need for advocates, who are volunteers that aid a specific patient with their treatment plan while accompanying them to any exams or tests that they may need. While speaking of the way that the CCMP runs on volunteers and a staff that does not receive any salary, but instead runs on “strength” and the “independence” of being a non-government funded organization, I could tell that Luz was very passionate about the work that she did. As I began to take down notes of her passionate speech, I realized that my fieldwork had begun.

**Interviews and Questionnaires**

While conducting my fieldwork I decided to use a number of methods to collect the data necessary for my thesis. In Law’s work *After Method*, he states that “methods, their rules, and even more methods’ practices, not only describe but also help to produce the reality that they understand” (Law 2004, 5). Keeping in mind of how the use of my chosen methods would potentially create information and knowledge on this specific organization and its volunteers, I made sure to be open to any new methods that could arise during my fieldwork as I wanted to be able to fully understand my field site and any information that was given to me by my informants. I also wanted to be as accurate as possible when not only collecting data, but also while writing my master’s thesis.
Included amongst the methods that I used was that of informal interviews, as well as the use of unstructured interviews and semi-structured interviews when conversing with volunteers and patients. I personally found the informal interviews to produce a substantial amount of data. Unstructured interviewing was also immensely beneficial as Bernard points out opportunities for unstructured interviews, as well as informal interviews and everyday conversations, can happen in any place at any given moment (Bernard 2006, 210). I utilized the method of unstructured interviewing when formally interviewing both Luz and Elizabeth (“Beth”) as they were not only the lone two twenty-four hour volunteers at the CCMP location, but also the volunteers that I had the most contact with. The method of semi-structured interviewing was chosen when I had the chance to formally interview the two doctors that volunteered for monthly medical and podiatric sessions.

For Luz and Elizabeth’s interviews I created questions that focused on the structure of the organization. I asked them what it was the Coalition of Concerned Medical Professionals does. Is the CCMP a free healthcare clinic? How many patients did their volunteer doctors treat within a single month? What is it that their volunteers do exactly? What are the activities that the CCMP participates in and organizes? I also asked Luz and Beth about the logistics of how the organization manages to run on a daily basis.

I also asked them more personal questions as I wanted to truly understand their reasons and motivations for their continued volunteer work. I asked Luz and Beth where they found the passion and recurring strength necessary to conduct this type of work as a full time job. I also conducted informal and unstructured interviews with Luz and Beth on almost a daily basis, as they were more than happy to share their opinions on the current situation that the American people face when obtaining healthcare insurance and services and treatments. These informal conversations, which mainly occurred during our lunch break, were a constant source of information on multiple topics for me during my fieldwork.

In terms of the interviews that were conducted with the volunteers and doctors, I was concerned about creating a certain level of ease. I wanted my “informants [to] feel comfortable responding to [my] questions” (Bernard 2006, 216) so that I could be given as much information
as possible. I began with certain prompts to find out how they first heard, and later came to be a part of the Coalition of Concerned Medical Professionals. As my fieldwork continued I became more confident within my interviewing skills and I learned the correct ways to address respondents who were more than willing to share their opinions and views, as well as with those that were not as elaborate in their responses. I also learned the correct manner to effectively probe answers from my informants. Once my interviewing skills were honed I began to ask why doctors and volunteers continued volunteering. While interviewing the two doctors that conducted monthly sessions at the CCMP I asked if the different environment in which they volunteer affected them in any way, i.e. I inquired if they preferred the set-up at the CCMP in which they were able to examine and spend as much time as they wanted with their patients. I also asked if healthcare insurance or language had ever been an obstacle in the diagnosis and treatment of a patient. I also asked them about their general thoughts on the current state of the healthcare system in the United States. I also recorded each conversation and interview as to keep a “permanent archive” (Bernard 2006, 227), making sure to inform the participants beforehand and getting their permission to do so.

In order to collect more data and personal opinions on certain topics, I created a questionnaire for the patients that visited the CCMP. While creating the questionnaire I thought that I could perhaps make a comparison with some of the provided demographics and statistics of people without healthcare. As soon as I assured some of the patients that their names would not be recorded, nor the legality of their status within the country, many of the patients agreed to help me with my research.

The questionnaire read as follows in English:

Age: ________________________________    Sex: Woman □   Man □
Native Country: ______________________  Race: _______________
Native Language: _________________
What is your average household income?: ______________________________
Have you ever tried to obtain health insurance before? If so, what kind?:  _____________
Have you ever had health insurance before? If so, what kind?: _____________________
How did you first hear of CCMP?: ________________________________
What struggles have you faced trying to visit a healthcare professional?: _______________

The questionnaire proved to be an experience, both during the filling out of the forms and after I had collected them to analyze. I would have liked to have created a questionnaire in different languages if possible, and used simpler wording in my questions as I found myself not only having to translate the questionnaire entirely for those who did not speak English, but I also had to further explain what I had meant with certain questions. If I am being perfectly honest the act of having to explain questions and provide translations caused some stress for me, as I was worried that I would not receive honest answers, if any answers at all. In the end 35 patients from all ages, economic backgrounds and races filled out a questionnaire. However a majority of the questionnaires remained incomplete. As multiple questionnaires were incomplete, they did not provide much data, if any data at all. Also, I chose to not have a statistical correlation to what I observed at the CCMP and the statistics I complied beforehand. Therefore the questionnaires are not utilized within my study.

Methodological Realization and Shift

Though Bernard has pointed out that participant observation is the “foundation of cultural anthropology” (Bernard 2006, 342), and while I used participant observation the most while watching how the mailouts, phoning and outreach worked, I found my methods beginning to shift and transform during the course of my fieldwork. During my time at the organization I still observed what was happening but I also began to utilize other methods as well. While collecting data I tried to capture as many moments as possible via photographs; I managed to take photographs of the overall layout of certain rooms within the CCMP office by using my smartphone. While I initially took photographs the first day that I visited the organization, I did not take as many photographs, if any photographs at all, as my time at the organization
continued. I was so focused on trying to capture every word said, either through recording or by taking notes, that I forgot about capturing the moment in visual form. As time went on I eventually decided not to try and take any more photographs, nor did I use the photographs in my analysis.

When I began my research I strove to take down every note that I could while still attempting to be attentive to what was happening around me. I set out to use as many senses as I could to illustrate what I experienced during my limited time in the field. As I gathered more notes, I began to notice that most of the data that I was collecting did not come from questionnaires or even interviews, but simply listening to what people had to say, proving that “participant listening is an important technique” (Forsey 2010, 558).

Without any prompts numerous patients and volunteers would openly and gladly give me their opinions on particular topics. With this new method in hand I opened my ears to what was around me. I simply began to listen to not only the conversations that I was having with others, but the conversations that others were openly having around me. This new act of participant listening allowed me to be aware of much more, as before I would have taken the time to simply go over written notes that I had accumulated earlier in the day, missing out on the opportunity to collect more data by simply listening. Listening would prove to be “at least as significant as observation” (Forsey 2010, 561) during my fieldwork.

My field not only included the Brooklyn location of the Coalition of Concerned Medical Professionals but began to grow to include other locations as well. These locations included doctor’s offices, school classrooms, and entire neighborhoods that I would visit along with the volunteers of the CCMP as they attempted to spread the word about the organization, recruit more volunteers and doctors to their cause while asking for both monetary and material donations. As my field began to grow I suddenly realized, that as emphasized by Coleman and Collins in the book *Locating the Field*, “in a world of interconnections, we never leave the field (cf. Appadurai 1988, 35: Gardner 1999) …” (Coleman and Collins 2006, 5). Instead I had to redefine what my field was. It was no longer a single building in Brooklyn, but multiple buildings and spaces. I had to hone my skills as a researcher and attempt to better myself at my
“craft”. As Coleman and Collins explain in their work, my field was not a static fixated place, but instead was an “emergent from” (Coleman and Collins 2006, 5) that continuously shifted and transformed each day.

**Multiple Roles, Internal Conflicts and Implications**

While gathering the data that would later compose this thesis I took on multiple tasks during my time as a researcher, and eventual time as an intern and volunteer. The moment I walked into the organization’s office as an intern/volunteer I was treated in both the same, and yet in an entirely different manner. I was greeted by the same people but my tasks had changed dramatically. I could no longer sit on the sidelines and watch as I did before and moderately participate (Wind 2008, 80); when acting as a researcher I merely observed and recorded as much as I could. However as an intern I now had to “get my hands dirty” and participate in all tasks that I had been observing just a few days prior. The lens in which I viewed this area had now shifted focus. I could no longer merely watch Luz and the other volunteers give a presentation about the CCMP, but now had to stand up amongst them and help them make the presentation. I was now told what our goals, or as Luz and Elizabeth called it the “Battle Plan”, for the day were as I was expected to be a part of every aspect. I was now a part of the Coalition of Concerned Medical Professionals. It was because of this that I began to consider myself one of those that I’d been observing and soon found myself inquiring about the wellbeing of certain patients.

During my time as a volunteer, I would take on different roles. I would even act as a translator. I strove to be as correct in my translations and conversations as possible while utilizing all four languages that I know. I spoke English with the majority of patients and volunteers, followed closely by Spanish, and in a handful of instances I spoke Italian and French. However, I did not realize that I would be eventually be conducting translations in a much higher, and different capacity.
As there are a multitude of people that need healthcare services and treatment within New York City, there is an immense need for people that speak more than one language. Though Luz can speak Spanish, she is often the only advocate at a medical, dental, or podiatric session that can do so. There have also been an increasing number of patients that speak Hindi. With these reasons in mind Luz approached me and asked if I wanted to, and could become a translator.

Though I had partook in conversations in Spanish, French, and Italian they were never in a professional or medical context. The conversations that I had with patients were unofficial and for my research only, as such they were informal and riddled with grammatical errors. The conversations that I would theoretically be having would essentially be a matter of life and death. I would have to translate what the doctor, prescription instructions, or any other document pertaining to their healthcare dictated.

For these reasons I doubted my skills in each language and declined Luz’s initial request. However as I continually saw the need for translators within the organization I eventually accepted the role as a translator, and began to act as a “go-between” for the doctors and patients during medical sessions. This new role that I accepted affected me in many ways. When first entering the field I did not think about how acting as a translator would affect me as an anthropologist. I truly began to understand the value of translator to a researcher. If something is misinterpreted or mistranslated in any way it can lead to many different issues later on. I will admit that the task of translator frightened me immensely, and I was in a constant state of doubt. I was in a continual state of worry and hoped that I would not make an error that would cause a patient their life. I mainly utilized Spanish and found myself going over medical terminology in the language in order to give the patient the best translation possible. I even utilized a translation app on my phone in times of doubt, though felt uneasy witnessing a patient and consulting physician watch me as I searched for the proper word. Generally I attempted to use the simplest words possible as to not only confuse the patient, but to not confuse myself and stick to what I knew best. All in all, it was a task that produced a significant amount of stress during my collection of both quantitative and qualitative data. However, acting as a translator, and as an intern/volunteer in general, also gave me access to multiple consultations.
During my time as an intern and volunteer I would also participate in calling up volunteers, as well as trying to recruit new volunteers, and would even act as an advocate. Like all the other tasks within CCMP, the role of the advocate was organized. Before the medical sessions were to start, I was to go over the patient list, gather their medical file and go over their list of symptoms that I had gathered over the phone a few days prior. I was also supposed to briefly inform the doctor of my patient’s symptoms before the examination began.

In Gitte Wind’s 2008 article “Negotiated interactive observation: Doing fieldwork in hospital settings” the issue of a redefinition of the concept of participant observation is brought up, as well as the proposal for something that Wind calls *negotiated interactive observation* (Wind 2008, 79). The act of participant observation within a hospital or clinic is a topic that holds no significant amount of literature (Wind 2008, 79), and as such there is no discussion on what it means to be an active participant in such settings (Wind 2008, 81). While conducting my own fieldwork I recognized many of the issues brought up by Wind. As a researcher I was not able to fully or properly become an active participant in what I was observing (Wind 2008, 81) as I was limited by confidentiality given to doctors and patients, administrative work that needed to be completed by other volunteers I was observing, and time restrictions. It is because of issues like these that Wind calls for the notion of negotiated interactive observation, which is the conduction of fieldwork without the assumption that you will become a part of those that you are studying (Wind 2008, 87). When reflecting on the way I completed my own fieldwork, I can see that I tried to adhere to this notion as much as possible. However that was not possible when I became an intern/volunteer even though I still remained a researcher. As such, I began to question my role as a researcher when acting as an intern/volunteer.

While composing my thesis, I worried that I would have a certain bias about particular doctors or patients, as well as the ethical implications of my double role in the organization. I even wondered if my role as an intern/volunteer superseded my role as an anthropologist. Patients and volunteers now looked to me as someone who fully supported their cause, and did not relate to me in the same way as they did before. It was easier for me to ask questions and form bonds with those around me. I was now an object that could also be observed, as well as
included more in their social engagements and their multiple feelings (Wind 2008, 84). To them I was no longer a researcher there to collect information, but one of them. As such, certain volunteers and doctors were a bit puzzled when I would ask them if they would like me to answer certain questions of theirs as a volunteer or as an anthropologist. While acting as an intern/volunteer I still acted as a researcher as I now had access to information and situations that I would not have had access to otherwise. As a volunteer and intern I was given more access to patients. From these interactions I was able to gather more information. I was also given more time and access with doctors and other volunteers allowing me to collect more data.

The manner in which I went about collecting data, paired with the methods that I used, had certain implications for my findings and even the way in which my thesis would later be shaped. While collecting the data necessary to create my thesis, I was sure to constantly inform those of illegal status that their details would be changed within the thesis itself. However, some distrust still remained and did not allow for the collection of as much data as I would have hoped for; the sense of distrust remained until I further integrated myself into the CCMP by becoming a volunteer during my time there as an intern. Also, the method of utilizing a questionnaire did not have the results I hoped for either, as the uninsured patients that did fill out questions of the questionnaire did not fully comprehend my reasons for it, or how it could yield any data. My strive for having a thesis free of bias may have also created an obstacle for me, as I made sure to ask certain questions of the volunteers and patients at the CCMP during my fieldwork that would generate certain answers. All in all, the implications of my methodology, and the manner in which I utilized it, resulted in an ethnographically rich data collection that was without the statistics that I had initially hoped for,
Chapter Three: New HealthCare System, Same Old Problems

The healthcare system in the United States of America continues to be a topic of contention for its politicians and its inhabitants. Politicians continually work to reach an overall agreement and a healthcare system that includes a comprehensive budget and solutions for all included, not only for those that can afford it or are of a particular socio-economic status.

In the United States healthcare insurance and its services are provided by many organizations and businesses, with most healthcare facilities being owned by businesses in the private sector. As debates over a reform of the healthcare system continue to expand and grow, and such statutes as the Affordable Care Act (ACA) are signed into law, many inhabitants are still left without options. A surprising number of those inhabitants occupy New York City as the United States continues to lag behind European counterparts in terms of access to care and services, treatment, medication and even life-expectancy.

The Affordable Care Act, also referred to as “ObamaCare” is a comprehensive healthcare reform that was signed into law in the year 2010. This new act was a significant turning point in the history of the United States healthcare system. However as hospitals, insurance agencies, medical providers, and patients adjust to this new legislation, in the overall structure of the healthcare system some establishments, like healthcare insurance providers and other businesses within the healthcare sector whose primary goal is to make as much economic capital as possible still exudes power.

This chapter not only outlines the history of the healthcare system in the United States from its creation in the late nineteenth century to the more current reforms, but provides background context for further ethnographic chapters in terms of reforms and regulations that have affected patients in different ways. Organizations such as the CCMP act as political advocates in an effort to try to reshape healthcare that has become a commodity.
The History of the U.S. Healthcare System

In the very beginnings of the formation of the United States there was no healthcare system in place so to speak of. Instead “physicians”, who also acted as barbers or members of the clergy, merely relied on instinct and common sense to make a diagnosis. The consulting physician would then charge the patient for whatever services they provided. The patient would pay the physician out of their own pocket and the transaction was complete. However during the turn of the nineteenth century beginnings of public health and healthcare insurance began to form as many changes within medicine, hospitals, technology and knowledge of human anatomy began to grow.

As a nation the United States has provided certain services for certain citizens of their union. More specifically, services were provided for those who worked in certain labor markets. Reforms and regulations have shaped the healthcare system of the country as far back as the 1800s, when workers within certain textile and trade industries would get injured while completing jobs thereby requiring medical treatment. Since then, certain services were created to insure the wellbeing of particular workers in order to ensure that the needs of certain businesses were met. Workers that were in such jobs as mining and steel, along with other hazardous jobs, had access to doctors that were provided by the company that they were employed by (Toland 2014, “How did America end up with this health care system?” Pittsburgh Post-Gazette, n.d. Web). Workers within certain industries also began to form their own unions to deal with illnesses or injuries endured from their work (Toland 2014, “How did America end up with this health care system?” Pittsburgh Post-Gazette, n.d. Web).

It was in the year 1847 that individuals, who were not provided healthcare services by their employer, could purchase health insurance as if buying any other material object (Niles 2011, 8). It was also in the year 1847 that the American Medical Association (AMA) called for changes to the method in which healthcare services were delivered. This organization, which was a membership for private medical providers, also established the need for physicians to be educated in some manner within the medical field (Niles 2011, 4). Barbers, and their red and
white striped poles outside of their shops which signified blood and bandages, were no longer socially accepted to act as surgeons and physicians (Niles 2011, 3).

It was later on during the late nineteenth century, the 1890s to be exact, that hospitals began to grow in number within the U.S. As such, certain regulations and implements were a necessity. With the turn of the new century and the growth of hospitals, the number of performed surgeries grew. Along with the growth of surgeries performed, doctors began to voice their opinion about particular services that were being offered in the hospitals that they worked in. Some doctors now stated that they should no longer expected to provide services to patients that could not afford to pay (Healthcare Crisis: Healthcare Timeline. PBS, n.d. Web).

As the nineteenth century brought new technological advances in medicine, further knowledge about the human body and its functions, as well as the new appreciation for cleanliness and antiseptics, opinions on the way in which healthcare should be delivered changed. During the Progressive Era in the U.S. (1890s - 1920s), which was a time that saw progressive political and social reform in the country, there was actually a call for a nationalized healthcare insurance program. However this argument failed as certain medical providers worried about how a potential healthcare program would affect their income. As a result of this fear medical providers persuaded the federal government to support the notion of private insurance (Niles 2011, 9).

With the support of private insurance in place, certain effects were beginning to be felt by those who had health insurance. As the cost of healthcare insurance rose in the 1920s (Healthcare Crisis: Healthcare Timeline. PBS, n.d. Web), hospitals and doctors began charging patients prices that seemed unreasonable and unaffordable (Toland 2014, “How did America end up with this health care system?” Pittsburgh Post-Gazette, n.d. Web). Searching for a solution to this issue, while still aiming to please private physicians who were once more concerned about their income, a hospital insurance was formed. From this, the basis for the nonprofit Blue Cross plans were created (Niles 2011, 9).

Essentially what the Blue Cross offered was health insurance to local community organizations (Noah 2007, “A Short History of Health Care” Slate, n.d. Web). This non-profit
health insurer also managed to keep costs at a low price. Initially the organization even charged everyone the same prices regardless of their age, sex, or any pre-existing medical conditions or issues (Noah 2007, “A Short History of Health Care” Slate, n.d. Web). Once private insurers began offering their services the Blue Cross changed their system and are today “virtually indistinguishable from other health insurers” (Noah 2007, “A Short History of Health Care” Slate, n.d. Web). As such commercial insurers soon began to follow suit, setting up the United States’ modern healthcare insurance system (Toland 2014, “How did America end up with this health care system?” Pittsburgh Post-Gazette, n.d. Web).

It should be noted that in the history of the United States’ healthcare system there have been multiple attempts to introduce universal healthcare. However those attempts continually failed in favor of having a healthcare system that provided certain companies with large economic profits. President Franklin D. Roosevelt’s attempt to “build compulsory health care into the Social Security act” (Toland 2014, “How did America end up with this health care system?” Pittsburgh Post-Gazette, n.d. Web) failed to be signed into law, while the era of the Great Depression forced attention towards having benefits for the elderly and unemployment insurance (Healthcare Crisis: Healthcare Timeline. PBS, n.d. Web).

With World War II and the participation of the United States in the war, companies began to compete for remaining workers in the country. As a result, companies began offering health benefits. This would eventually lead to the current employer-based system (Healthcare Crisis: Healthcare Timeline. PBS, n.d. Web), becoming the “‘cornerstone’ of [the United States] system of healthcare provision, ‘as vital to [our health] as the drugs, devices and medical services that the insurance covers,’” (Toland 2014, “How did America end up with this health care system?” Pittsburgh Post-Gazette, n.d. Web).

By the 1950s over half the American population would have hospital insurance; 60% to be precise (Niles 2011, 9). However the 1950s also saw the price of hospital care double and those who did not have employment found it increasingly difficult to access the necessary care. Throughout the next decades multiple presidents advocated for different solutions to unaffordable healthcare insurance and unattainable healthcare services, as well as treatment.
While over 700 insurance companies offered some form of health insurance (Healthcare Crisis: Healthcare Timeline. PBS, n.d. Web), President Lyndon B. Johnson signed the Medicare and Medicaid programs into law in the year 1965. These programs, which in short “protect the elderly, disabled, and indigent” (Niles 2011, 8), currently insure over 105 million Americans (Toland 2014, “How did America end up with this health care system?” Pittsburgh Post-Gazette, n.d. Web).

By the 1970s the cost of health insurance was on the rise (Noah 2007, “A Short History of Health Care” Slate, n.d. Web) in part because of high Medicare expenditures, economy inflation, medication costs, hospitals expenses and declining profits (Healthcare Crisis: Healthcare Timeline. PBS, n.d. Web). While all these issues were occurring at the same time corporations fought over control of the costs of healthcare in order to try and raise their income and profits, while cutting their own personal costs (Toland 2014, “How did America end up with this health care system?” Pittsburgh Post-Gazette, n.d. Web). It was during this time that President Richard Nixon established what would later be known as the Health Maintenance Organization (HMO), “which focused on effective cost measures for health delivery” (Niles 2001, 9) and would be a predecessor for managed care (Niles 2001, 8). It was also during this time that President Nixon’s call for a nationalized healthcare insurance was rejected (Healthcare Crisis: Healthcare Timeline. PBS, n.d. Web).

During the turn of the new decade corporations started to join healthcare businesses and the hospital system, thereby beginning the corporatization and privatization of healthcare that started in the 1980s (Healthcare Crisis: Healthcare Timeline. PBS, n.d. Web). However the Consolidated Omnibus Budget Reconciliation Act of 1985 saw the requirement of employers to offer partially subsidized health care to employees that are let go from employment (Niles 2011, 8). It was also in the year 1982 that Medicare programs shifted to diagnosis related groups (DRGs), which charges a patient pertaining to their diagnosis (Healthcare Crisis: Healthcare Timeline. PBS, n.d. Web), that controlled insurance reimbursement costs (Niles 2011, 8).

By the 1990s the cost of healthcare rose at double the rate of inflation as Federal healthcare reform legislations failed to pass within the U.S. Congress (Healthcare Crisis:
Healthcare Timeline. PBS, n.d. Web). However in 1993 the Family Medical Leave Act was passed, which allows employees up to 12 weeks of unpaid leave due to family illness (Niles 2011, 8), and 1997 saw the passing of the Balanced Budget Act which aims to control Medicare spending (Niles 2011, 8). At the end of the century there were 44 million Americans without healthcare (Healthcare Crisis: Healthcare Timeline. PBS, n.d. Web).

The new century has seen much of the same trends in terms of the healthcare system as healthcare costs are still on the rise and nearly 60% of Americans obtain health insurance via their employer (Niles 2011, 9). Medicare remains the largest healthcare program, while the Children’s Health Insurance Program sought to make sure the children who are not eligible for Medicaid receive healthcare (Niles 2011, 9).

The Current Healthcare System in the United States

The healthcare system in the United States is operated by a number of organizations. However many healthcare services and institutions are owned, and therefore operated, by businesses within the private sector. As such a distinct separation and stratification of healthcare distribution is created, and a large number of citizens are left without the proper healthcare services in this capitalist driven field.

Of the United States citizens that have acquired healthcare insurance, a portion has done so via their own or a family member’s private personal insurance that they have purchased. The majority of U.S. citizens that have obtained healthcare insurance have done so through an employer, while the remainder are uninsured and must pay for any acquired healthcare expenses from their own funds.

Healthcare in the United States has been viewed, and consequently turned into, a commodity in a market driven system throughout the years of its limited existence. The United States has continually spent more on healthcare per capita than any other nation in the past few years (Global Health Observatory Data Repository, World Health Organization, n.d. Web) and is expected to exceed $4 trillion in healthcare spending by the year 2016 (Niles 2011, 2).
It should be noted that 58% of United States community hospitals are currently being defined as non-government “non-profit” hospitals, which act as non-profit organizations. This allows non-profit hospitals to be exempt from state, local, and federal income taxes. 20% of hospitals are government owned hospitals, and 21% of hospitals are defined as investor-owned “for-profit” hospitals. “For-profit” hospitals generally charge the highest amounts for treatment in order to create a profit for their shareholders (Fast Facts on US Hospitals, American Hospital Association, n.d. web). Healthcare centers and clinics have different aspects in which they operate and run their facilities, and are not defined in the same manner as hospitals.

However, the healthcare model within the United States continues to create inequality in terms of unequal access to healthcare. Those lucky enough to have coverage are increasingly paying more and/or receiving fewer benefits. The increasingly complex conflicts between insurers and hospitals over who pays the bills is gobbling up a great deal of money and resources, and the end result is that the United States pays roughly twice as much per capita for health care as Canada, France, and the United Kingdom yet experiences slightly lower life expectancy than those countries and significantly higher infant mortality. These problems in the U.S. healthcare system are literally killing people, as “employers are reducing or eliminating outright health-care benefits for employees” (Noah 2007, “A Short History of Health Care” Slate, n.d. Web), while hospitals become less and less willing to help patients of a low income.

In the year 2010 the Affordable Care Act (ACA) was signed into law. While representing a significant reform in the U.S. healthcare system within the past 45 years (Horton, Abadia, Mulligan and Thompson 2014, 2), it strives to financially transform hospitals and lower the costs of healthcare by simultaneously improving healthcare distribution and accessibility. The ACA has established guidelines to ensure that a basic set of benefits are received (Horton, Abadia, Mulligan and Thompson 2014, 6), while seeking to lower the rate of uninsured Americans via the expansion of insurance, both public and private.

However, it should be noted that the ACA does exclude those that do not have legal documentation to be in the U.S. (Tiedje and Plevak 2014, 2). As such, some 11.2 million undocumented migrants have limited access to healthcare (Tiedje and Plevak 2014, 2). Due to
the limitation in access to healthcare, many undocumented migrants utilize the services at a hospital emergency room (ER) as a last resort if the circumstances are dire. Once leaving the ER they are given expensive bills to pay, with very little chances of being able to pay such a bill, and to afford any medication that may be needed (Tiedje and Plevak 2014, 4).

The ACA strives to reduce the cost of healthcare for not only the government but for private individuals. The Affordable Care Act also saw the expansion of healthcare services to those as old as the age of twenty-six by being able to stay on their parent’s insurance coverage, aimed to increase health equality (Horton, Abadia, Mulligan and Thompson 2014, 2) while expanding employer-based insurance and Medicaid, and reducing systemic inequalities. The new law also requires all insurance companies to cover all applicants via the new set standards and offer the same rates (The Week Staff 2012, “ObamaCare survives the Supreme Court: 5 takeaways”, n.d. Web).

Individual mandates, which is a law that requires that people either purchase or obtain a specific service or good, also require individuals not being covered by employer based insurance, Medicare, Medicaid or other insurance programs to pay a penalty fee (Geilwitz 2010, “Consumers Guide To Health Reform:”, n.d. Web). Companies and businesses employ a certain number of employees are also ordered to offer healthcare insurance or pay a penalty. While the healthcare reform seeks to patch the rapidly hemorrhaging system, there are those who still suffer from the inequalities within the healthcare system.

Though there are different types of hospitals that may help patients of various economic backgrounds, there are still those that are unable to afford hospital services and treatment. It is thus important that organizations like the CCMP exist, as well as free healthcare centers and clinics. These organizations, programs, and centers allow patients to be treated and potentially saved, as they would not have a chance to seek healthcare otherwise.
Chapter Four: A History of Struggle

The Coalition of Concerned Medical Professionals is an organization that is composed of a group of people that are no strangers to struggle, whether it be a conflict with health insurance agencies or issues with laws imposed by the county health departments. These health departments, who are not only in possession of power, continuously exercise their abilities (Olssen 1999, 19) to control local businesses and even local law enforcement. The control that these health departments can exercise may be an issue for the healthcare institutions and organizations that go against them. The people that volunteer at the CCMP have faced multiple hurdles throughout the organization’s existence. Although the CCMP does not always emerge from their battles as the victor, their dedication and fight for comprehensive healthcare for all does not waver.

When first joining the Coalition of Concerned Medical Professionals it is mandatory that a new volunteer take a “course” of sorts about the history of the CCMP. According to Luz, it is important that one understand what the CCMP has evolved from. The course is given so that the volunteer understands that the history of the organization is an integral part in the way the CCMP runs today. It will forever be a grassroot organization that will not accept funds from the government, or any other big corporation for that matter. The CCMP is an organization that does not wish to be restricted by rules and regulations about who they may or may not help. It is required that a volunteer take the course in the hope that new volunteers will be encouraged to engage in political advocacy in the fight for a comprehensive healthcare system in the U.S.

The history of the organization also allows one to conclude that those who are active in the CCMP adhere to, or at least agree with, certain opinions that are related to healthcare. Those opinions include that healthcare should be a right and not a privilege, and that people are not objects to be controlled. As the U.S. healthcare system has become a commodity, the body is now an instrument to be controlled (Foucault 1975, 11) and manipulated in order to make more profit for certain companies and corporations in the healthcare provider business. The CCMP does all in their power to fight against this injustice.
In order for one to see the CCMP as a field that has been produced by the positions of individuals within the social structure of the U.S. healthcare system, one must first understand its history. When the history of the CCMP has been explained, one can then view the CCMP as a structure that is characterized by certain schemas that are a result of certain social practices (i.e. discrimination against uninsured patients).

The History of the Coalition of Concerned Medical Professionals

The Coalition of Concerned Professionals is an organization that provides a year-round, free-of-charge, preventive medical benefit program that aids multiple people via the donations of skills and monetary funds. According to their own definition that volunteers within the organization provide upon flyers and in its “history course”, the organization is:

“an entirely free and voluntary unincorporated association of health care professionals, students, low-income workers and their families, clergy and other concerned citizens fighting for the right to truly comprehensive healthcare for all, regardless of ability to pay. CCMP is committed to alleviating the plight of low-paid workers, the poor and anyone without adequate medical coverage through an independent, community-supported approach. CCMP accepts no government funding nor any moneys with strings attached so as never to compromise the association's principles.”

In order to try and grasp what it is that the CCMP aims to do, one should first familiarize themselves with the CCMP’s history. The history of the CCMP is not written in any other format than the history that has been noted down by the board members. This document covers the organization’s span from its creation in 1973 all the way to the year 2004.

CCMP was established in 1973 and worked alongside the Eastern Farm Workers Association (EFWA) in Suffolk County as Long Island showed the worst condition of farm workers in the country. The workers, who were brought in to work on the Long Island fields from all over the U.S. and the Caribbean, were recruited by crew chiefs and suffered injuries from the equipment. These workers also developed difficulty breathing and low life expectancy. The workers that did work within this dangerous field were not even technically classified as
employees. Instead, they were categorized as migrant and seasonal workers. The migrant and seasonal workers completed jobs that were extremely low paying in an extremely hazardous field. Such hazards included health issues caused by chemicals, potato dust, and even alcoholism. Alcoholism developed mainly due to the fact that the employers would pay the farm workers in wine instead of with monetary wages. These bodies of workers that were to be ruled were stuck in a “system of constraints and privations, obligations and prohibitions” (Foucault 1975, 11) with no hopes of breaking from such a rigorous system of oppression.

As such, farm workers began to unionize in order to get the healthcare services and treatment they needed. Influential organizations such as the Black Panthers helped organize the first clinic at a service center. This clinic saw about 60 patients a week. However the clinic soon came under the scrutiny of the county and harassments in the form of unscheduled visits and false claims soon followed. A grand jury investigation of the service center was conducted due to claims of drugs, prostitution and other fabricated allegations. The service center eventually chose to close, moving the equipment to an undertaker’s home. Soon after that the equipment was moved once again and organizers started to recruit doctors to see patients at their own private practices.

From these efforts a worker’s benefit council formed. The benefit council proved to be advantageous as typhoid eventually was found to be migrating up from Florida. As a result of these new findings independent screenings for typhoid were soon organized. Though typhoid was not found, other health problems were and seizures caused by temic and tuberculosis became rampant. It was then that the Coalition of Concerned Medical Professionals became an organization in an effort to deal with these illnesses.

On June 6th 1973, CCMP’s first board meeting was held and the preventive medical benefit program was created as well as the CCMP’s Statement of Principle. From the CCMP’s efforts treatments for workers were procured, and an occupational health project was created as the CCMP strove to utilize resources within the community.

As the CCMP soon began to grow to include more medical sessions, St. John’s Pharmaceutical School volunteered to operate a dispensary that resulted in the better treatments
of workers. The CCMP also began to promote the importance of preventative care. The Coalition of Concerned Medical Professionals was also able to help during disaster relief, such as when Hurricane Belle hit in 1976 by utilizing resources within the community. In fact, referrals were sent to the CCMP when other clinics, such as the Red Cross, could not handle the amount of patients that would visit their facilities. Though the natural disaster proved to be a difficult obstacle, this particular situation led the CCMP to expand.

As the same time as the Coalition of Concerned Medical Professionals began to join meetings and get involved within the Migrant Health Policy Board, tuberculosis (TB) was found in 1979 at the Northfolk camp and at Greenport. A total of 83 people tested positive for TB signs. The CCMP would later take these results and refer them to the Riverhead County Health Department (RCHD). The CCMP also documented their findings to the Center for Disease Control (CDC) in Atlanta. As the RCHD did not appreciate the CCMP documenting their findings to the CDC and being reported, the RCHD apparently began to bother and harass the CCMP. In an effort to try and close the CCMP, the RCHD claimed that the Coalition of Concerned Medical Professionals was acting as a food establishment because of the food donations the organization accepted. This harassment by the county gave the CCMP unnecessary issues, for if they were indeed a food establishment they would require additional licenses that they currently did not hold. The CCMP would thus be in violation of multiple codes and acting as an illegal food establishment.

As time went on the CCMP filed a lawsuit against Riverhead County, as the county went to the State Department to try and shut the CCMP down. After this the State Department began an investigation. The Coalition of Concerned Medical Professionals then filed another lawsuit, changing the status of their lawsuit from a state case to a federal case. As Riverhead County began to further harass the CCMP by conducting more unscheduled visits, the CCMP lost the case that they filed against the State Department. As Riverhead County maintained that there was no TB and that it was not contagious, TB began migrating in jails and drug resistant strains of TB developed.
As this disease continued to spread the Coalition of Concerned Medical Professionals began to lose doctors, and other volunteers, due to the fear of the loss of contracts and licenses in the county. Riverhead County also started to make demands of the CCMP. The county demanded that the CCMP be licensed as a diagnostic and treatment center. The county even managed to have the State Police sent to the service center. Police officers went through private files via a warrant with the help of county police, which violated constitutional amendments. The County had this done in an effort to obtain medical files about patients with TB, so as to inhibit any necessary treatment that they would have to provide the patients. As the battle between the Coalition of Concerned Medical Professionals and the Riverhead County continued, the State Department of Health eventually ruled that the CCMP was a diagnostic and treatment center. As the lights and heat within the CCMP service center were turned off, the CCMP chose to retain their energy, resources, and further years of legal actions and chose to once again move.

The Coalition of Concerned Medical Professionals eventually chose to move out of Long Island and into New York City. For a few years, their services were located in the Borough Park area of Brooklyn. Their office was located above an optometrist's office and contained the same basic set up as it does in their current location, consisting of a single exam room and an office space. While at this location, the CCMP began to conduct general dental sessions (GDS), general medical sessions (GMS) and general pediatric sessions (GPS). However, as the sale of the building and increasing rent became an issue, the CCMP chose create stability through location and purchased their own building in the Canarsie area of Brooklyn. It is in this building that that they are currently located.

Though the CCMP no longer has any issues with local government authorities or agencies, nor are they recognized as a medical center, they face struggles every day. The organization needs to raise at least $200 per day to make up the $6,000 a month for the $50,000 that the organization loaned from three private parties for the purchase of their current building. The organization also needs to raise enough money for the upkeep of the building and utilities. Though the organization may have its difficulties it currently aids approximately 20 patients a week. The organization also continually battles certain policies put into place by the United
States government in the simple hopes that no patient will ever be denied the care that they so desperately need. With donations provided by organizations, businesses and private persons, those that work and volunteer at the Coalition of Concerned Medical Professionals are able to make a difference in many lives.

As the history of the CCMP shows, the organization is not one that has had an easy go of things. The history of the organization is riddled with obstacles, however it shows the volunteers of the organization and those that they fight for and against, that they are an organization that does not give up easily. The history of the CCMP shows not only the political aspects of their work, but also their activism. The CCMP is not afraid to fight against agencies of power, authorities, and private interests in order to break down the social divisions that cause injustices within healthcare. It is thus important for a volunteer to truly understand what the organization has been built up from and currently stands for if they wish to be a part of the organization themselves; an organization that seeks to combat deeply entrenched inequities in access to healthcare.

The CCMP has been formed as a product of collective practices (Moore and Sanders 2006, 412) in the U.S. healthcare system that discriminates against particular groups of people. In response to the agencies of power that have created social stratifications, the CCMP allows a dynamic social space (i.e. a field) to be created in the premises of their Brooklyn location in which patients are be treated no differently than patients that can afford to obtain healthcare insurance and its services. People who volunteer with the CCMP, generally agree with the aims of the CCMP, and usually are an example of how volunteers and physicians are not merely “‘technicians of the microphysics of power’ (Foucault 1995) [but] active agents [that are] pushing back against and transforming the structure, even as they operate within its constraints” (Davenport 2000, 324). Two volunteers that not only agree with the aims and mandate of the CCMP, but have devoted a large part of their lives to the organization are Elizabeth “Beth” Stevens and Luz Figueroa.

The sections on Elizabeth “Beth” Stevens and Luz Figueroa will describe instances in which institutions of power (i.e. healthcare agencies and corporations) utilize biopower in order
to retain control and power of the body of the patient. These sections will also depict the perception of the uninsured patient by these two particular volunteers of the CCMP. These volunteers in particular may be perceived as those who try and keep the field of the CCMP intact (i.e. intact in terms of treating all patients with respect and integrity, as well as politically advocating for the right to healthcare), while volunteering a substantial amount of their time and energy to the organization.

Elizabeth “Beth” Stevens

When I first met the firework that is Elizabeth “Beth” Stevens, I was struck by her constant passion and dedication. Upon our initial contact she immediately began to speak of why it was so amazing that I had decided to use the Brooklyn location of the CCMP as a field site. She also began speaking about all the injustices that occur on a daily basis. She explained that every volunteer that walked through the door could make a difference. She was also very determined to have massive changes occur within the healthcare policies of the United States government.

Beth was also on her way out the door to spread the word about the organization, advocate for the right to health, and hopefully rally new volunteers. Beth was always in a constant state of movement and motion. She was constantly out and about attempting to recruit new doctors in multiple areas of medicine. She would also attend public talks that pertained to either healthcare policies or healthcare rights, and always made sure to be present at the talks prepared with studies and statistics of the hardships of those who could not afford the necessary treatments or procedures. Beth was constantly at public events that dealt with healthcare regulations. She had a very analytical and critical point of view on the healthcare system including the important role of the control of knowledge and different techniques of discipline bodies in sustaining unequal relations and the power of certain actors and institution (Samuelsen and Steffen 2004, 9).
Elizabeth Stevens is the current active President of the Brooklyn charter of the Coalition of Concerned Medical Professionals, and would be one of the most interesting people that I would meet during my time at the organization. In one of the more calm moments around Beth, I managed to grab her attention. The following hours would contain her trials and tribulations with the organization over the course of more than thirty years volunteering.

Elizabeth, who first came into contact with the CCMP in the year 1978, describes herself during this time as a “white girl from the suburbs of Boston, who after graduating with a bachelor’s degree had money, a hell of a lot of time, and a fancy new sports car”. Beth had initially been interested in women’s health and volunteering with an organization dealing with issues relating to this specific issue. However, after being given a flyer by a CCMP volunteer Beth became a volunteer with the organization instead.

I was intrigued by Elizabeth’s constant vigor and her energetic manner. She would constantly be thinking of new methods in which to recruit new doctors and their skills. Elizabeth dedicated her life to this organization. Agencies of power utilize biopower to turn the body of the individual into a docile body (Samuelsen and Steffen 2004, 8) that is to be treated in a manner that is as cost-saving as possible; Beth has fought against this injustice:

Elizabeth: “As to how I can have the constant energy and the passion?”
Jennifer: “Yeah, I mean...you live upstairs. You and Luz are the only two volunteers here. This organization is a...large portion of your life.” I tried to explain without potentially offending her.
Elizabeth: “This organization pretty much is my life, you can say it. Every time a GMS or a GDS comes up I still get a thrill. Hell, even a GPS.” she laughed as she brought up what I had been secretly thinking.
Jennifer: “I didn’t want to assume anything.”
Elizabeth: “I have things I do. I like to go to the movies. I love music. Luz loves dancing, and she has a beautiful voice. But...the amount of corruption that goes on in the healthcare sector is appalling. Did Luz ever tell you about that kid from the Dominican Republic? Hector?”
Jennifer: “No, she didn’t. Do you mind if I ask what happened?”
Elizabeth: “Leukemia. And of course the health insurance agency gave us some bullshit story about why they couldn’t cover him anymore. The treatment was too expensive, they said. They even questioned his place of birth and whether or not he was a citizen.”
Jennifer: “Why would they do that?”
Elizabeth: “Well you know this Obamacare claims that they cover everyone, but they don't. They don’t cover anyone that doesn’t have papers.”

Jennifer: “So you’re saying they don’t cover illegal immigrants?”

Elizabeth: “No. Obamacare doesn’t. But Hector wasn’t illegal, he was a U.S. citizen. And we couldn’t find a doctor who would take the case in time so…” she said as she stood up from the kitchen table and walked over to the fridge. The silence in the break room, where we had been conducting the interview, suddenly grew as I waited for her to continue talking.


Elizabeth: “Well…” she began and hesitated as she searched the contents of the fridge. “...sadly, he died. Fifteen. Terrible, I tell ya. Just terrible. But, that’s what they do. The health insurance agencies, and the hospitals, all these reforms that’re supposed to help everyone and be all inclusive. They’re not. They exclude people. If you can’t pay they throw you out on the street and let you die. They don’t care.”

Jennifer: “But you care. That’s something!” I tried to be encouraging.

Elizabeth: “Yes it is. But sometimes it isn’t enough.”

Beth had many more stories, like the one above, which illustrate the way that powerful agencies have commodified healthcare, invest within the body, mark it, and train it in order to keep their hold upon it (Moore and Sanders 2006, 353). In all the stories that Beth shared the use of biopower was apparent, as the agencies of power treated the uninsured patient as an object.

Elizabeth Stevens is not a woman that shies away from conflict, nor is she a woman to stand down from a fight. Whether she is narrating instances in which she and a patient are in court battling injunctions made by insurance companies, her stories are rich in number and always filled with emotion. The most telling story of Elizabeth’s, in my opinion, is her confrontation with the New York State Police and the Riverhead County Health Department which is yet another example of biopower and how certain institutions will go to extreme lengths to keep their hold over the body of the patient.

As Elizabeth has been a member of the Coalition of Concerned Medical Professionals since the late 1970s she has been an integral part of a large number of activities and events within the organization’s history. When first hearing the story of how the New York State Police Department and the Riverhead County Health Department began unscheduled visits to the CCMP’s location in Long Island, I instantly asked her if there was anyone currently volunteering

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4 *Law*. A judicial process or order requiring the person or persons to whom it is directed to do a particular act or to refrain from doing a particular act. (dictionary.com)
within the organization that I could possibly interview as I desperately wanted to hear a firsthand account of the situation. When I was told that Elizabeth had been there on that alarming day, I immediately knew that I had to ask her about it, if only to hear her personal experience with these agencies:

Jennifer: “Can you tell me about the day the police and the health department came into the CCMP’s Long Island location?”

Elizabeth: “Well...I was only a kid then really, you know, in my early twenties. And uh...the cops just burst through the front door with some guy from the health department waving some warrant in our faces. And their guns. And I tell you, Jennifer...I was so scared. I mean I was terrified. I was twenty-three and here I was just trying to help out farmers and other sick people, and I have a shotgun pointed at my face. And for what? So the county doesn’t have to pay for people to be healthy? So they can keep their money and their power over everyone else, to silence anyone that dares try to speak up? Not me. I may have been scared but I spoke my mind! I stood my ground.”

Listening to Elizabeth's story of being held at gunpoint, for the mere sake of a county retrieving patient’s medical records in order to avoid any necessary treatments that they would potentially have to provide TB patients, was an eye-opening experience. When first hearing these stories I internally had some doubts and skepticisms as the stories seemed hard to believe. Unfortunately my time at the CCMP proved otherwise. However, there are people like Elizabeth Stevens that dedicate their lives to continuously fighting the injustices that occur within the healthcare system, where agencies of power inflict strategic punishment over the individual body (in the form of withholding treatment) in order to keep control over the economic factors that are related to the body (Foucault 1975, 25) (i.e. gaining monetary wealth from patients paying for treatments and medications, etc.).

Luz Figueroa

When I first heard of the Coalition of Concerned Medical Professionals I was a bachelor’s student at Hunter College in New York City, and the first person that I met was Luz Figueroa. Luz would end up being the person that I would spend the most of my time with
during fieldwork, as well as a source of multiple details about the healthcare sector within the U.S.

Luz first came into contact with the CCMP in 1984 when the organization was camped out on a sidewalk corner with a table and some information about their organization. Interested in the organization’s beginnings, what the CCMP stood for and Luz’s own personal experience with farmers without healthcare, she decided to become a volunteer.

As the manager of operations Luz has many daily tasks which include the managing of volunteers, food collections every Thursday, administrative assignments, the payment of bills, and the oversight of the GDS, GMS, and the GPS. Despite her many complex, and sometimes difficult, tasks Luz insists that she would not have it any other way. According to Luz, she and the other volunteers at the CCMP are “building an organization that can represent the interests of the people it's fighting for”.

Luz is a woman in her forties who has also dedicated her life to this organization. As she lives upstairs in the apartment above the CCMP office with Elizabeth, she is the only other twenty-four/seven volunteer at the organization. Luz, who can be characterized as a soft-spoken yet hard-working and warm-hearted woman, is the daughter of a farmer who migrated from Puerto Rico. Seeing the hardships that her father endured in his choice of labor she automatically felt a sort of kinship with the organization’s interesting establishment, and their fight against how healthcare agencies invest in the individual body, which is given worth in relation to its economic use (Foucault 1975, 25):

Jennifer: “Was there any other reason for joining the CCMP? Other than having a father that was a farmworker, that is?”
Luz: “Oh, yeah. Of course. How can you see the needs of these people and not help? I mean you see people in pain and they are casted aside because they can’t pay for a treatment or for medication. Healthcare is a right not a privilege. And yet corporations have turned the healthcare system into nothing more than a business. It could cost them $1 to make a pill but they would care you $100 for it. All so that they can make a profit. And if that patient doesn’t have the money to make them profitable, then they’re casted out. They’re not deserving of the treatment that these agencies can provide. They’re not worthy of an investment, so they’re not worthy enough to live.”

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Jennifer: “Can you give me any examples of instances where doctors have refused to help the CCMP or volunteer their time and services?”

Luz: “Oh yeah, of course there have been times where that had been the case. And the reasons why some doctors don’t wish to help are mixed. Some doctors are simply not interested in helping, and that’s okay. Everyone is entitled to their own opinion. Other doctors simply have their hands tied by hospitals or other healthcare agencies and can’t help.”

Jennifer: “Can you talk a little bit more about that last part?”

Luz: “Well not too long ago the CCMP had this doctor that was truly wonderful. She is a very smart woman and a great doctor. She had been volunteering here for years and years. Unfortunately though, she had troubles with her employment. You see, insurance companies and the hospital administration board had told her that she was only allowed to spend five minutes with each patient.”

Jennifer: “Five minutes? Certain daily tasks take more than five minutes.” I tried to find the logic in that statement. “How can a doctor examine, diagnose, and set up the necessary follow-up exams or treatments in just five minutes?”

Luz: “That’s exactly what this doctor said. She said that she couldn’t give a patient only five minutes of her time when giving them seven or eight minutes may be the difference in saving their lives.”

Jennifer: “What happened?”

Luz: “Well the insurance agencies told her to stick to five minutes, or else they would sue her and make her pay out of pocket for all the extra minutes she spent with patients. And you know what? They sued her. For over a hundred thousand dollars.”

Jennifer: “There’s no way that happened. It’s just not possible.”

Luz: “Oh, it’s possible. And it happened. And she spent so much time battling against it that she barely had time to continue working, let alone volunteering so...she stopped. And it’s really unfortunate because she was a great volunteer.”

Jennifer: “I can’t believe she was sued. Wasn’t she just doing her job?”

Luz: “You have to understand that after a point, to certain people that is, patients become no more than simple objects and dollar signs. And every day we try and fight that. And that’s what matters in the end.”

Luz and Beth are the CCMP’s only twenty-four/seven volunteers at the Brooklyn location. Though to some it may appear that these women have potentially given up their own lives to try and save those of others that they have no affiliation to, it is not that way for these strong women. Instead Luz and Beth have witnessed insurance companies and corporations in the healthcare sector turn the body of the patient into something that is to be controlled and manipulated. Luz and Beth both agree that institutions of power have created relations of domination in which the body of the patient is extorted whenever deemed fit or necessary.
(Foucault 1975, 26). These independent, lively, and intelligent women wake up every day with a set purpose to try and fight the injustices that are created by certain health insurance companies and businesses in the healthcare sector that act as agencies of power. With particular knowledge in hand about the current rules and regulations in healthcare, as well as what happens to those without access to healthcare services and treatment, they seek to inform the public about the corruption that takes place within certain medical institutions and settings. Although Luz, Beth, the medical professionals and other volunteers at the CCMP are not always victorious, their spirit never waivers as they continue to fight for universal healthcare for all.

Those that volunteer at the CCMP do so in many different ways as the organization has many different aspects to it. The organization not only provides free healthcare services to those that would otherwise not be able to seek treatment, but is also present in the political aspects of certain healthcare issues. As such, the CCMP creates an interesting field for the volunteer to interact in. However, it is important that to be able to attempt to help an uninsured patient, one must first understand the perception of, and what it is like to be an uninsured patient.
Chapter Five: The Wall Street Businessman and the Undocumented Migrant

If a prompt was given in which one was to imagine someone that does not currently hold a healthcare plan, or is able to afford the services available to those that do have healthcare insurance, particular popularized opinions (doxas) and stereotypes may arise when describing a person in that situation. Such stereotypes may relate to the person’s race, sex, legal status, or even their education level. This creation of the stereotype and social stigmatization of one’s identity is rooted within the culture that the individuals inhabit (Olssen 1999, 31). The result of such a stigmatization causes those who are not in the possession of certain services (i.e. healthcare) to be seen as a second class citizen of sorts, as the care an uninsured patient may receive would be considered lower quality, and more likely to suffer from substandard care (Becker 2004, 260). The perception of an uninsured patient may also be related to the thought that an uninsured patient is undeserving, as to be deserving of a service within the U.S. has the social definition of being able to be productive and therefore having access to wealth (Becker 2004, 260).

Prior to coming into contact with the Coalition of Concerned Medical Professionals, I too had such perceptions (as the aforementioned) about those that I would potentially be coming into contact with. However, at the end of my fieldwork and internship at the organization I saw that the current healthcare system does not solely discriminate against those of a certain sex, race, age, or religion. Simply stated, if one is not able to pay for healthcare they are not given access to its services and treatments. Access to medical treatment is not restricted to simply being uninsured but a class based phenomenon (Becker 2004, 259).

During my time at the CCMP I met and interacted with people that may fit the stereotypical perception of a person that does not have healthcare insurance. It is a fact that during my time at the CCMP I met and interacted with illegal migrants that worked in certain industries, were paid under the tables, held no papers, and could not speak English. However, I also met and interacted with Harvard graduates that worked white collar jobs, had once worked on Wall Street, and could interact and converse in multiple languages.
The role of the uninsured patient in the reproduction of social stigmas about themselves is an issue also needs to be addressed. Certain actions, though seemingly harmless in the mind of the uninsured patient, add to the creation of social stigmas and stereotypes (e.g. missing examinations, showing up late to examinations, unwilling to miss a day’s work in order to have a diagnostic test performed out of fear that they will be let go from their employment).

It can be argued that the healthcare system within the United States is designated for people that belong to a specific socio economic class. However, when at the CCMP it is apparent that healthcare is designated for those who can afford it, regardless of their education, race, sex, or legal status. The following sections will focus on the multiple types of patients that I came into contact with and their perceptions of what is an uninsured patient, as well as being an uninsured patient themselves. These sections will also highlight how the uninsured patients inadvertently add to the creation of the stereotype and social stigma of the uninsured patient.

The Businessman and Those with White Collars

Incorrect assumptions are made every day about the status of a person based on multiple factors. People are judged based on their speech, their appearance, their job title, even the color of their skin. These assumptions that are made also lend themselves to the creation of the perception of where a person may fall within a particular social stratification. One may incorrectly make assumptions about what it is that a person is in the possession of and what it is that they are not.

Frankly speaking one can say that if a person is in the possession of a white collared job with a fairly good education, they should also be in possession of health insurance because of the common constructed belief and popular opinion (doxa). However, that is not always the case. At least it was not the case at the Coalition of Concerned Medical Professionals.

As previously stated, I held certain assumptions about the patients that might ask for the CCMP’s help. I assumed that the patients asking for help from the CCMP would correlate to

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5 The term white collar/white collar job refers to the various types of work that can be performed in an office, or in an administrative setting.
certain statistics that I had collected during preliminary research. These statistics claimed that as of 2012, the total populous of New York City equates to that of 8.337 million people. Of these 8.337 million people, one in four (1 in 4) do not have health insurance. Of these uninsured residents, most inhabitants make up a certain age group as well as a certain demographic. Of the uninsured, approximately 41% are categorized as Hispanic and approximately 49% are within the age range of twenty-five years to forty-four years old (Uninsured New Yorkers after Full Implementation of the Affordable Care Act, n.d. Web). Because of other statistics that correlate with the aforementioned, I incorrectly assumed that I would also come into contact with a mainly Hispanic group within a specific age bracket. However, I was constantly surprised by the ever-changing types of patients that I would meet and their perception, feelings and experiences of being an uninsured patient:

Jennifer: “If I can be so bold as to say, and hopefully not offend but...how can you possibly not have healthcare insurance?”
Jack6: “Well in many ways that’s a black and white answer. And in many ways it isn’t.”
Jennifer: “Can you elaborate on that?”
Jack: “Well...you probably look at me and think ‘Here’s this old white guy in his mid-fifties. Has a job. Looks like he’s fairly put together and takes care of himself. He’s even worked on Wall Street.’ Oh, yeah! If you didn’t know I worked there just a couple months ago actually...” he rambled on.
Jennifer: “I didn’t know that. What happened, if you don’t mind me asking?”
Jack: “I lost my job. You know, the economy still isn’t the best. No matter what the news say and those statistics show...there are lots of people losing their jobs every single day. And unfortunately I was one of those people. And with that pink slip, I lost many things. One of them being my health insurance.”
Jennifer: “So you had health insurance that was employer based correct?”
Jack: “Yup. And was paying hundreds and hundreds a month. Thousands and thousands a year. Of course I never got sick or anything, so I didn’t need to use it except for once or twice. And when I did I got treated right away. I was treated with respect. When I would talk to the doctor about what I was feeling, they listened. Of course, as soon as the damn thing is gone I’m treated like a failure. I can’t pay for healthcare insurance so I failed at being a proper citizen somehow.”

6 Jack will be the alias utilized for the actual patient that I encountered while at the Coalition of Concerned Medical Professionals. I encountered Jack two times during the length of my stay as a researcher and intern.
The feeling of being a second class citizen, or a failed citizen, is a notion that is not new to the field of medical anthropology. As the U.S. has turned healthcare into commodity, it is a common perception that if a citizen has not procured enough wealth to obtain access to healthcare insurance, and healthcare services, they are in some way a lesser citizen. One can take into consideration the traditional American values that relate to individual responsibility and productivity (Becker 2004, 260). If the individual is not productive enough to gain the economic means, this is related to the individual’s worth and may have an effect on the individual’s self-esteem (Becker 2004, 260):

Jennifer: “I don’t want to pry or anything…”
Jack: “Go ahead and ask! I don’t mind. I like sharing my story.”
Jennifer: “Well, it goes back to some of those things you said. Shouldn’t you have some money saved up, in case you did need to go to the doctor or have some sort of examination done?”
Jack: “I didn’t make the smartest investments during my younger years, and even when I was working. I basically lost everything when I was let go from my job.”
Jennifer: “Why don’t you have health insurance now?”
Jack: “Well, I simply can’t afford it. Even if there is this new healthcare act that’s attempting to help people, I mean if I don’t get some kind of damn insurance I get punished?! I have to pay because I can’t afford to get the damn insurance in the first place? My employer doesn’t give me insurance! These business corporations do everything they can to get around it so they save as much money as possible, all so that they can keep it for themselves! Even though I’m considered to be a full-time employee, I still don’t qualify. I need to work forty hours a week.”
Jennifer: “How many hours a week do you work to be considered full-time?”
Jack: “Well I work thirty-nine hours, but would need to work forty hours to have health insurance provided for me by my employer.”
Jennifer: “Is that legal?”
Jack: “Of course. This new “ObamaCare” says it’s there to help everyone, but it simply doesn’t. I mean, even if I did have health insurance the amount I would have to spend on a copay7 would be ridiculously expensive. I just can’t afford that on my salary. I have a job and yet, I have no insurance. And I’m not the only one.”
Jennifer: “Do you know anyone else that doesn’t have health insurance?”

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7 Copayment: a small fixed amount required by a health insurer to be paid by the insured for each outpatient visit or drug prescription. (dictionary.com)
Jack: “Oh, yeah. Actually a lot of my former co-workers are in the same predicament as I am. And of course there are the younger folks that I work with at the moment. They think they’re young and invisible, so...of course they don’t need health insurance.”

Jennifer: “How did you hear about the CCMP?”

Jack: “I was just at the right place at the right time. I was at the grocery store when I saw Luz and some other volunteers talking about what it is that the CCMP does and how they can help. I had been feeling sick recently, and was worried about how I could afford to see a doctor. But then the CCMP helped me... I’ve even told some of my former co-workers about this organization. And even those young ones too. Everyone should be able to get healthcare. Or at least know about an organization that knows the right people; or get in contact with the right people.”

Jack’s case was a shocking, yet refreshing eye-opener. The current economic condition in conjunction with the current healthcare system does not affect merely one type of person, it affects many. Jack’s testimony shows how when one is in the possession of healthcare insurance one is treated with respect, and given immediate attention, and is not quickly pushed through the procedures necessary in receiving treatment (Becker 2004, 268). Alongside Jack, I encountered multiple patients of varying races, sexes, and economic incomes that simply could not meet the conditions required for them to receive healthcare from their employers. These multiple types of patients counteract the stereotype of what it is to be an uninsured patient. The uninsured patient is assumed to have no healthcare insurance due to the inability to afford it because they are too lazy to seek employment, thereby deserving of the treatment they are receiving (Becker 2004, 268).

Among those patients was Alan, a twenty-five year old IT-technician that could not afford to have health insurance and needed urgent care for an infection he had contracted. Emma, a sixty year old retiree who needed help obtaining medications, and Sue a forty-eight year old single mother who needed multiple examinations in order to diagnose chronic pain that she had been suffering from.

In other cases, as aforementioned, co-pays could also be the inhibitor, alongside other restrictions. As stated by Jack, it is imperative that someone be aware of how to properly navigate the healthcare system in order to access the necessary procedures and care, even to someone who would be seen as being in possession of symbolic capital. Symbolic capital, the
prestige, honor or recognition one is given as well as resources, holds some economic value and is a form of power and mode of domination. This form of capital may be “the most valuable form of accumulation in a society...” (Bourdieu 1977, 179), especially that within the U.S. which has turned the healthcare system into a commodity which appears to value economy and profits over the lives of those they are there to serve. There were other instances in which I did come into contact with those that may potentially fit into the stereotypical picture of those that would not be in the possession of healthcare insurance and access to healthcare.

The Undocumented Migrants and Those with Blue Collars

It would be correct to state that the notion of the illegal migrant is a prominent perception of someone that is unable to obtain healthcare insurance. With the current political climate being what it is within the United States in terms of its current debates on the topic of immigration, the ACA not allowing illegal migrants to seek healthcare coverage, and those illegal migrants that continue to reside within the country, many people are left without options. Those left without options are a part of a substructure (i.e. lower social class) that is a result of privileging structures constructing a gap (Moore and Sanders 2006, 9) between the social classes.

When working at the CCMP it is to be understood that anyone that walks through the doors is to be helped regardless of their legal status. When a potential patient is aided by the CCMP they are to be treated in the same manner as everyone else. Their status outside of the CCMP’s doors do not matter in terms of them potentially receiving care. The CCMP strives to make every patient they help feel comfortable, and hope that it is understood that their legal status is not an issue of concern as their primary concern is to heal their body.

While at the CCMP I had encountered undocumented migrants from multiple countries, with most being from a Latin origin. In fear of being deported to their country of origin, they resisted seeking medical or dental care up until the last possible minute. Because of the fear of deportation or expenses they could not afford, they developed a certain philosophy (Becker

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8 The term blue collar/blue collar job refers to the various types of work that deal with manual labor. Those that are blue collar workers are usually considered to be a part of the working class.
2004, 263) about seeking healthcare. Due to feelings of discrimination due to the fact that they were uninsured, they developed a certain unwillingness in seeking care (Becker 2004, 267). In certain cases, they attempted to cure their ailments with home remedies, some even going to drastic measures to cease the pain that they were feeling:

Jennifer: “You have a lot of illegal immigrants that come through the CCMP doors, correct?”
Luz: “Well our patients are from all over, and come from all walks of life. But that doesn’t mean one is necessarily treated in a different way than the others. But to answer your question, yes. We have illegal immigrants seeking care from the CCMP.”
Jennifer: “Has a patient’s legal status ever been an issue?”
Luz: “What do you mean exactly?”
Jennifer: “Has a physician or anyone else refused care, or to help because of a patient being an illegal immigrant?”
Luz: “No, thankfully not. Our volunteers, those that truly believe in the cause anyway, are not deterred because of their patient’s status. They simply see them as someone that needs help.”
Jennifer: “Can you recall any cases of someone not seeking care when they should because of their status as an illegal alien?”
Luz: “Oh, of course. There are tons of cases like that and it’s unfortunate. We always make sure to tell our patients to spread the word about this organization. Anyone that needs help will receive it as long as it’s in our power.”
Jennifer: “What was the worst case you’ve ever encountered yourself that dealt with an illegal immigrant not seeking care when they should have?”
Luz: “I’d have to say it was a case that we just started working with actually. It has to deal with a forty-three year old woman. Are you familiar with the case?”
Jennifer: “No, I can’t say I am. Can I have some specificity about the case?”
Luz: “Well this woman called the CCMP the other day after being in pain for some time.”
Jennifer: “Does she need medical care?”
Luz: “No, this time it’s a dental issue. You know that the CCMP has root canals donated right? That’s tens of thousands of dollars donated every year.”
Jennifer: “I didn’t know that. But that’s great that you know dentists that are willing to volunteer their services like that!”
Luz: “It truly is. We’re very lucky to know the right type of physicians and people in general that are so generous.”
Jennifer: “So does this woman need a root canal? Or is another type of dental procedure that she needs?”
Luz: “Well this patient was concerned about asking for help because of her legal status, so instead of seeing a dentist for the pain that she has in her mouth she actually tried to carve out one of her teeth with a kitchen knife.”

Jennifer: “Excuse me?”

Luz: “No you heard right. She actually did that!”

Jennifer: “That’s horrible.”

Luz: “Yes, it is. This woman was scraping away at her teeth and gums with anything that she could find because her pain was so unbearable. And in her mind she didn’t have any choice because she didn’t know who to turn to for help.”

Jennifer: “How did she hear about the CCMP?”

Luz: “I think she was referred to by a friend. Someone told her to stop taking her treatment into her own hands and get some real help.”

Jennifer: “Did she do a lot of damage to herself?”

Luz: “Well I had to literally tell her to stop scratching at her teeth and gums with a knife, so yes there was a considerable amount of damage. But we’ve gotten her to see a dentist so there’s hope. She will need to have a considerable amount of oral surgeries though. I’m just happy she called when she did. Or else it could have been a lot worse.”

Jennifer: “And there are other cases like this that you’ve dealt with?”

Luz: “Oh yeah. Although the patients usually don’t try to perform surgery on themselves. Thankfully, that is! Once they come into contact with us, we get them into contact with the people that are qualified to deal with such issues.”

Jennifer: “So in the end it comes down to being informed about such things?”

Luz: “Well there’s the knowledge about such things, but there’s also the fear of asking for help. If you can’t afford health services on your own, then you should at least have the proper information to be able to seek out such services in another way. Or at least an organization that can help you out. That’s why we try so hard to spread the word about our organization. No one should have to suffer like that. No one. But unfortunately even if there is an organization that offers free help, certain people will still stay away out of the fear of being judged as they did something wrong, or that they’re lower than those who can afford to seek treatment.”

While gathering information at the CCMP I came to know about other patients that attempted to cure themselves of their ailments. At the startling realization that there was more than one case in which a patient attempted to cure themselves via home remedies, I began to inquire the details of the cases in which the patient took drastic measures to alleviate their pain due to the fact that they felt defeated by the healthcare system (Becker 2004,269). Among one of the most shocking testaments was about a man named Alberto.

This patient, aged thirty-six and illegally staying in the U.S. from Guatemala, had suffered a leg injury some time before coming to the CCMP for help. However, since he was not
able to see a doctor out of the fear of being deported, being judged at not having no healthcare insurance, not wanting to be treated as someone inferior, and not having the monetary means to pay for care, Alberto had his leg improperly treated by a family friend. As such, his leg was causing chronic pain on a daily basis. Hoping to alleviate his pain, he too began prying into his leg with a kitchen knife. Fearing that he contracted an infection his friend, who was a former patient of the CCMP, recommended that he go to the organization and see a doctor.

It is a saddening fact that cases like these are numerous. Unfortunately, when one is not in possession of the right resources, knowledge, or in contact with someone that does have the right knowledge of where to procure the necessary treatments, cases like this occur. Fortunately, the CCMP does all it can to ensure that their cause is known to as many people as possible. From their efforts, multiple lives are saved every day. However there are certain limitations to the ways in which those at the CCMP can go about treating a patient as there are multiple constraints that the volunteers have to deal with.

**Hindrances for Maribel**

Maribel⁹ would be the patient that I had the most contact with during my time at the CCMP. Her case, which prompted certain emotional responses from me which would make me question my role within the CCMP and possible ethical consequences, allowed me to view the ways in which biopower caused missed medical encounters, as well as the ways in which the patient themselves may add to the creation of the social stigma and stereotype about the uninsured patient.

When handling Maribel and her sensitive situation, all those that were involved wanted to make sure that she received the best care possible. However there were certain obstacles that kept that from happening. Whether it was Maribel’s employer or Maribel’s consulting doctors

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⁹ Maribel will be the alias utilized for the actual patient that I encountered while at the Coalition of Concerned Medical Professionals. I encountered Maribel a handful of times during my time as a researcher and her eventual advocate.
(and to a lesser degree even Maribel herself), these particular obstacles prevented Maribel from obtaining the proper care she desperately needed, resulting in missed medical encounters.

In the case of Maribel’s employer, Maribel feared the mere thought of asking for the day off. As she was illegal and had many family members within and outside of the United States depending on her income, Maribel was not willing to do anything that would jeopardize her income:

Luz: “Well we could always write a note to your employer, or even have the doctor write something that states that you need a day off to have multiple tests done. If that helps we’ll do that.” I witnessed Luz say.

Maribel: “Oh, no... that wouldn’t help me. No.” She said in an almost frightened manner as she spoke to Luz in Spanish.

Luz: “How about a phone call from me or Beth? Or your consulting doctor? The sooner we get these tests done, the faster we can give the x-rays and test results to Dr. Smith10.”

Maribel: “Oh, no...I can’t. You can’t. I have to work. Please, don’t.”

Luz: “Maribel...I know you’re scared. But you have to understand that these tests need to be done. Until these tests are done Dr. Smith, or any other doctor for that matter, cannot give you the treatment you need.”

Maribel: “It’s not worth the trouble. I can’t…”

Luz: “Your life is not worth the trouble?!” She asked in disbelief.

Maribel: “I need this job. It’s everything.” Maribel tried to reason.

Luz: “Your life is everything. And so is your family. From what you say you need to get better. And not only for them but for yourself. There will be other jobs. You only get one life.”

Though Maribel’s employer was a bit agitated to be called by Luz and the consulting doctor, Maribel’s employer eventually, albeit reluctantly, agreed to give her a single day off to have all the tests done that she needed. Although Maribel’s employer did not exactly say no to Maribel’s request, the looming fear and pressure to subscribe to the power that Maribel’s employer held over her convinced Maribel to not miss the day of work she desperately needed to.

Other obstacles that led to missed medical encounters not only came from Maribel’s employer, but unfortunately from Maribel herself. Maribel repeatedly told everyone at the

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10 Dr. Smith will be the alias utilized for the actual consulting medical doctor that I encountered during the CCMP’s medical sessions. I encountered Dr. Smith a total number of four times at the CCMP’s Brooklyn location during my fieldwork, and following internship.
CCMP that she could not afford to miss a single day of work. The few hours that she had already missed while traveling to Brooklyn and attending the general medical session would cost her greatly, and she was not willing to miss an entire day. Maribel would not even hear the idea of potentially contacting her employer, and was incredibly embarrassed and worried for her employment when her employer was eventually contacted by both Luz and Dr. Smith.

Once I had ended my time at the CCMP, I periodically kept in touch with those at the organization. As I asked Luz and Beth about Maribel, they stated that although her situation continues to steadily worsen, she will not take off a single day from work in order for her to get the medical help she needs. Instead, Maribel works as much as she can to provide for her family. Although she hopes she will be able to come in for an hour or so during one of the upcoming medical sessions. As the medical sessions are usually held on a weekday, or whenever the current consulting physician has donated their time, and are only held once a month the opportunities for Maribel to seek the proper treatment dwindles every time she chooses not to visit the Coalition of Concerned Medical Professionals.

In a rather odd contradiction of sorts, other factors that have continually contributed to Maribel’s lack of treatment has come via those who volunteer at the CCMP. As a patient is to be chaperoned to any diagnostic test, x-ray, or blood sample that is drawn, an advocate must be reliable and understand that they are an incredibly integral aspect of the patient's’ treatment plan. However, once I had left the organization, the advocates that had remained had not been able to accompany Maribel on such excursions. Granted, the remaining advocates at the CCMP did not have a specific date that was agreed upon between Maribel and the diagnostic center or hospital in which she would have the diagnostic test completed, but their constant hesitancy and withdrawal of tentative and potential dates only exacerbated the situation.

The consulting doctor, Dr. Smith even had a role in the Maribel’s treatment, or lack thereof. While initially adamant that Maribel get the help she needed as soon as possible, when it came time to call Maribel’s employer, he stated that he would rather have his secretary send a letter of some sort as he could not set aside a single minute to deal with the situation; instead Dr.
Smith was inclined to take care of his “customers” (patients) and deal with his business. Dr. Smith was also inclined to deal with research programs instead.

Even though Maribel did not get the treatment that she needed while I was there, I did manage to witness a complex contradiction of sorts. While at the Coalition of Concerned Medical Professionals, I witnessed the doctors themselves who are supposed to be the healing aid in this situation, and the other volunteers as well as the patients themselves hinder the treatment of the patient. In a rather contradictory manner, I still do not understand or begin to try and unfold, the situation remains and Maribel has not gotten any better.

Though there may be preconceived perceptions about those who do not have healthcare insurance and access to healthcare, there is a clear stratification in terms of healthcare. There is a system for those who can afford insurance, and one for those who cannot (Becker 2004, 271). This reaffirmation of structural and social inequalities in the healthcare system (Becker 2004, 271), is reproduced by the seeming unwillingness of the uninsured to seek healthcare and the limits of non-governmental organization and volunteers in dealing with the traits of the uninsured patient.
Chapter Six: The Volunteer and the Patient

One of the most common and frequent phrases that I heard during my fieldwork and internship within the Coalition of Concerned Medical Professionals was: “I need help. Please help me”. The cases of the patients that contacted and visited the CCMP spread across multiple demographics, incomes, races, and age groups in their search for healthcare services and treatment. However the needs of these patients remained the same in these matters of life and death. The needs of these patients were met by the different types of volunteers of the CCMP.

The volunteers at the CCMP did all that was in their power to try and obtain the necessary exams, doctor visits, and prescriptions in order to assist these people with their ailments and hardships. Of course the volunteers of the CCMP did all that was in their power to recruit more volunteers to respond to the needs of the ever increasing number of incoming patients who are cast aside due to the creation of misconceptions and misunderstandings about what it is to be an uninsured patient.

However, the opinions and mentality of the volunteers should be noted. Volunteering physicians at the CCMP may be an integral part of the organization, but the volunteers that spend the most of the time at the CCMP location should also be taken into consideration. While at the CCMP, I noted the internal battles of some of the volunteers as they confronted issues of human rights, U.S. laws and regulations and social tensions in a context in which some people do not approve giving the uninsured free healthcare (Tiedje and Plevak 2014, 2). At the same time as they were dealing with their own perception of an uninsured patient. The volunteers at the CCMP mainly went against the commonly accepted perception of uninsured patients (Tiedje and Plevak 2014, 2) and agreed with the notion of healthcare being a human right. However, it remained crucial that the volunteers at the CCMP not develop a certain negative mentality of what it was like to interact with uninsured patients (Rivkin-Fish 2011, 185).

Some patients began to become well known at the CCMP as they continually had ailments that needed treatment and care. Unfortunately, certain patients would require multiple doctor visits and exams, or would develop multiple medical or dental problems. These patients
would eventually require an advocate to help them along their difficult journey towards once again being healthy. The relationships formed between the patient and their eventual advocate was an important facet of the patient's treatment plan. At times the advocate essentially held the patient’s life in their hands. While at the CCMP I was an advocate, and the patient I helped was called Maribel. 

**Advocacy**

One of the CCMP’s trademark phrases is “See one, do one, teach one”. Whenever a volunteer is given a new task, the volunteer will first see the task being done. After seeing the task be completed the volunteer will then complete the task while being supervised. This volunteer then teaches the task to a new volunteer. When the new volunteer can complete the cycle, and teach another volunteer the task, the first volunteer is then considered to be “certified” and can complete the specific task on their own without further supervision. The CCMP is an organization that relies on systemic organizing and the role of the advocate follows that same structured organization.

When a volunteer first walks through the door of the Brooklyn location of the Coalition of Concerned Medical Professionals, it is a hope that they will eventually take on the role of that of advocate. The CCMP is in a desperate need of advocates. The role of the advocate is an essential part to the structure of the CCMP. The CCMP describes the role of the advocate in the following manner:

“The ultimate responsibility of all CCMP volunteer medical advocates is to safeguard the patient’s life and to facilitate the provision of life-saving medical treatment, in the context of CCMP’s free of charge preventive medical and dental benefits. CCMP trains and certifies advocates ‘on the job; with experienced volunteers training new volunteers. …

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11 Maribel is the same patient that I have discussed in Chapter Five which describes the various types of patients that I came into contact with during my time at the CCMP.
It is the duty of the medical advocates to facilitate all transactions between a patient and the volunteer doctor, to include carrying out the treatment plan and directed follow up, and to aid in organizing a consensus between the doctor, the patient, and themselves as to how to materialize a solution for patient.

The advocate must familiarize themselves with the comprehensive needs of the patient, via discussion with them and via their consent to review file materials. The advocate accompanies the patient through all stages of medical transactions, clarifying and providing additional information to the patient when needed. The advocate establishes a time-framed plan of action for follow-up, and carries out that follow-up through use of CCMP’s system organizing method to expand the quantity of organizational resources as needed.”

As the advocate not only informs the doctor of their patient’s symptoms before the medical examination, but also sits in upon the medical examination while documenting all of what the doctor states in the patient’s medical file, the advocate is an essential facet of the patient’s health. One can view the advocate as a broker of sorts that deals with all the “transactions” that deal with the patient. However a term that would be better suited to describe the advocate would be that of an intermediary, or better yet a mediator as the advocate also acts as a mediator between the consulting doctor and the patient. The advocate may even act as a translator for patients that need it.

During the medical examination, the advocate is also to make sure that the patient understands what it is that the doctor is stating. After the medical examination, the advocate is to once more go over what the doctor has stated and the supplemental follow-up procedures that are to take place, or the necessary prescriptions that are to be acquired. The advocate is even to assist the patient in the acquisition of the prescriptions if they do not have the means to do so on their own.

Essentially, the advocate is the keeper of the patient and is an essential part of a patient’s treatment at the CCMP. Although I am not privy as to the reasons of why the position of the advocate was created, one may conclude that the role of the advocate was created in order to ensure that the patient is in a constant state of comfort and involvement in their own treatment, and to make sure that they are not treated as an object. Instead the field of the CCMP is a medical setting that values the patient’s worth as a subject. In doing so, the CCMP has created a
position to ensure the integrity of the patient is kept while in the medical examination room. The role of the advocate could have also been created as to ensure that there is always another person other than the patient that is aware of the patient’s health and situation. This is crucial as the doctors that volunteer at the Coalition of Concerned Medical Professionals are in constant change and rotation.

An important aspect of advocacy is that a level of trust exists between the advocate and the patient. The patient needs to feel at ease with the advocate as the advocate will sit in upon their examinations and be privy to the details of not only their health history but certain parts of their personal history. It is also important that the advocate have the necessary skill to be able to communicate with the patient if the patient does not speak or understand English. These are some of the attributes that I had to adhere to when I became an advocate. These attributes also caused me internal debates about my position while in the field.

When acting as an advocate, I eventually began to question my role as an anthropologist. I pondered if my role as an intern superseded my role as an anthropologist on assignment. However, I was sure to tell Luz and Elizabeth that my role as an advocate would unfortunately be limited to the length of my internship. Ultimately, I became an advocate to one person, a woman named Maribel.

“My name is Maribel”

I first heard of Maribel while witnessing my very first medical session at the CCMP. Luz would be my mentor during my training to become an advocate, and I was to sit upon Maribel’s medical examination. Luz demonstrated the tasks the advocate was to complete during this time. Luz had briefly described her condition before her examination with the consulting doctor of the day, Dr. Smith12. Luz had told me that unfortunately, Maribel was not a new patient.

Instead, Maribel had previously been to the CCMP two years before. Maribel had had uterine and ovarian cancer, as well as a family history of cancer. On this day, Maribel was here

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12 Dr. Smith is the same doctor that I have referenced in *Chapter Five.*
because she felt a lump in one of her breasts. As her mother, sister, and aunt had all recently struggled with breast cancer, she feared that she would succumb to the same fatal family trait.

Maribel, a twenty-nine year old illegal immigrant from Honduras who did not speak a single word of English, had a look of forlorn etched upon her face as Dr. Smith conducted his examination. A look of sympathy and sadness was also found upon the doctor’s face as he continually took down notes within her medical file.

Dr. Smith was distressed about many things. Maribel currently had issues breathing, was underweight and continued to lose weight at a steady pace, and was concerned about a lump that she felt in her breast. As the voluntary doctor examined Maribel, I myself began to get nervous and immensely sad for this person who I had not known had existed only minutes before.

As I witnessed Luz translating what the doctor was telling Maribel, I took note of her demeanor and the suggestions she made via the language of her body (Jackson 2006, 330). I noticed how she began to slump over and form a vice-like grip upon the examination robe she had changed into as the worrying news trickled from Luz’s mouth onto Maribel’s ears. I also took note of her hushed, soft-spoken responses and the way her eyes searched the medical examination room as if the cure to her potential illness would be found among the cotton swabs or the doctor’s stethoscope.

Once the examination was over I observed the interaction between Luz and Maribel as Luz spoke with her, making sure that she understood what had transpired and what would occur in the upcoming days. Once every course of action had been understood, she thanked Luz and begin to leave. However, before she could leave I stopped her in the hopes of simply introducing myself:

Jennifer: “Hi. I’m Jennifer.”
Maribel: “Hello, My name is Mariella. But call me Maribel.”
Jennifer: “It’s nice to meet you, Maribel.”
Maribel: “It’s nice to meet you too.”
Jennifer: “I’m sure you’ll be okay. Luz and everyone else will make sure of it.” I suddenly said without any prompt and unknown reason.

13 The following interaction was conducted in Spanish and later translated into English for this thesis.
Maribel: “I hope so. Well, I have to go back to work now and I can’t be late. My boss won’t like it. She didn’t even want to give me today off.”

Unfortunately, I did not have the proper time to internalize the interaction that had just occurred as Luz needed my help while the GMS continued. As I steadily witnessed more interactions between doctor, patient, and advocate, my mind trickled back towards Maribel and the struggle that she was soon to undergo. As the GMS drew to a close, and Luz and the other volunteers for the day took note of the various diagnostic tests, procedures, and prescriptions that needed to take place, I found myself thinking about Maribel’s predicament:

Jennifer: “Luz, can I ask you a question?”
Luz: “Sure, what’s up?”
Jennifer: “Does Maribel have an advocate?”
Luz: “No, not at the moment. We need to get her one as soon as possible. Unfortunately I can’t be her advocate. We need another Spanish speaker to help translate.”
Jennifer: “Oh...well that’s too bad.”
Luz: “You could always step in and be her advocate if you’d like!”
Jennifer: “Oh, no. I don’t know about that. I don’t think I’d be comfortable essentially having another person’s life in my hands. Sorry.”
Luz: “That’s okay. Just let me know if you change your mind.”

My reasons for not wanting to participate in the role of advocacy were small in number. I did not have the utmost confidence in my ability to translate from Spanish to English, and vice versa. Also, I simply did not want the pressure and stress of having another person’s life rest within my hands. However, as Maribel’s worried look continued to haunt my memory, I resolved to help her in any small manner that I could. A week later, I found myself committed to Maribel and her health. I had become an advocate.

### An Advocate for Maribel

Though I initially did not wish to become an advocate for personal reasons, which included being unsure of the time that I could dedicate to ensuring that I could accompany a patient to all the exams and tests that they needed, as well as worrying about becoming
personally attached to the patient I would helping, I found myself contacting Maribel and informing her that it was I that would be her advocate. I would aid her in any way that I could during my time at the CCMP. I genuinely wanted to help this woman throughout her troubles, even if it meant that I would potentially be creating a situation that would result in ethical consequences due to my double role as a volunteer/intern and a researcher. As Maribel and I discussed the next course of action, she once more expressed her hesitation at seeking help at the expense of her employment:

Jennifer: “I’m looking over your medical file and the next step is that we need to go to a diagnostic center and have some bloodwork done. We also have to get you a mammogram so that the doctor can have a look at all your test results at the next general medical session.” I spoke to Maribel over the phone.

Maribel: “Are the tests going to be done all together? I can’t miss work.”

Jennifer: “I’ll try and talk to the diagnostic center, but if it can’t be done all at once then we can go another day. It’s okay.” I tried to be reassuring.

Maribel: “I can’t.” She quickly stated.

Jennifer: “But...you have to?” I questioned. Maribel’s health was quickly diminishing and I did not understand her hesitation or her resilience to undergo the necessary steps and procedures to be properly treated.

Maribel: “I can’t miss work. My boss doesn’t like it when I miss work to come here.” She explained.

Jennifer: “I understand...” I honestly didn’t, but said so anyway.

This hesitation to seek medical treatment, through no fault of Maribel, unfortunately aids to the reproduction of the doxa of the uninsured patient. When in a field like that of the CCMP, it is an unfortunate fact that certain volunteers already have a preconceived perception of the uninsured patient, and what it will be like to volunteer. Certain volunteers think that the patient will be grateful for any care they may receive. The perception of the uninsured patient, or the “failed consumer” (Rivkin-Fish 2011, 192) includes that: they have few entitlements to healthcare, they are recipients of charity, or that they should demonstrate gratitude for whatever care they receive (Rivkin-Fish 2011, 192), and that they should be satisfied with what they have received as the healthcare system is a structure in which you “get what you pay for” (Rivkin-Fish 2011, 196). I admittedly began to form my own perception of Maribel as an uninsured patient,
but soon corrected myself as I was not there at the CCMP to make judgement upon those I was not only researching but trying to help.

Meeting Maribel at a diagnostic center to undergo a mammogram and get her blood drawn, I attempted to talk to Maribel about other, lighter things to get her mind off the current situation. However, Maribel was incredibly silent. She only expressed that she had already lost a few women in her family to cancer, and did not want to join them so soon in her life.

Unfortunately, Maribel could not make it to any of the following medical sessions during my internship. As an undocumented migrant she worked as much as she could to provide for her family both here and back home, and feared that any request for time off would lead to her termination. By doing so, Maribel has unknowingly adhered to the accepted popular opinion that may be interpreted as the acceptance that those who do not produce enough capital do not deserve proper health coverage. Whenever I am in contact with those at the CCMP, I find myself asking about Maribel and her wellbeing, hoping that she has not taken a turn for the worse. Though my personal experience with Maribel provided me with firsthand experience with uninsured patients in the role of an advocate, I found that my hesitations and judgements were not entirely dissimilar to those held by the other advocates at the CCMP.

**Advocates and Appeals**

The role of the advocate is not easy, however it remains an important role within the CCMP that a volunteer can take on if they wish to do so. Not many that volunteer at the organization have an interest in eventually taking on the role of advocacy. The term “taking on the role” is one that is adequate when describing the role of advocacy, as an advocate must be in charge of numerous tasks that can end up being crucial in the treatment plan of a patient. The responsibility of essentially being an integral facet of a patient’s treatment and life is enough to worry any person, and it is important that the advocate not do anything that would in any way compromise patient care or reaffirm any negative stereotype or social stigma about the uninsured patient (Rivkin-Fish 2011, 185). However, it is especially worrying to that of a twenty-two-year-
old student finishing their undergraduate studies, a single mother, or an elderly woman attempting to do charitable acts during her retirement.

Harry\textsuperscript{14} is a twenty-two year old student that is currently in his senior of studies; majoring in biology, he thought that volunteering at the CCMP would be a great way to start witnessing how patients are examined and eventually treated. He also thought that it would be a good way to meet and interact with doctors. From these interactions, Harry assumed that he would be able to not only gauge the opinions of the volunteering physicians about certain medical topics, but also be able to have conversations in the hopes of beginning to network. Riddled with the stress of being a graduating senior, his own stigmatizations of the uninsured patient, and the personal responsibility of ensuring that his younger siblings were taken care of while his mother worked, Harry did not wish to become an advocate:

Harry: “Well...you saw how hesitant I was. And Luz was there asking me if I could become an advocate for that guy and...I couldn’t say no. I didn’t know how. I wanted to, but I couldn’t. And now I have to speak Spanish to him and I’m not even sure if mine is any good. I don’t even know if I have the time to! I’m graduating soon. Not to mention that I always have to pick up my younger brother from school and take care of him until my mom comes home. I don’t think I can do this for too long.”

Jennifer: “Well you should probably tell Luz then.”

Harry: “I don’t want to disappoint her, or the patient...I just don’t know what to do.”

Jennifer: “I think being direct is the best way.”

Harry: “Yeah probably. But to be honest, I should probably just stay his advocate.”

Jennifer: “Why do you say that?”

Harry: “Well, not be rude or assume to much but...I don’t think that guy is going to show up to too many exams and tests anyway. Did you see how he showed up over an hour late to the GMS today?! That’s just unacceptable!”

Jennifer: “I’m sure he had his reasons. Maybe he couldn’t get off work in time?”

Harry: “Still...he should’ve called someone here at the CCMP and told someone that he would be late. That’s the responsible thing to do.”

Unsure of how to proceed and unwilling to disappoint the patient or the other volunteers of the CCMP, Harry continued to volunteer whenever he could while still holding onto his perception of an uninsured patient. However, as he was consumed with his studies and his

\textsuperscript{14} Harry will be the alias utilized for one of the advocates that I met during my time at the CCMP.
previous responsibilities at home, he was unable to make the next two medical sessions. Though I am uncertain of Harry’s continued volunteer work as an advocate, I am told that he still manages to volunteer at the CCMP whenever he can.

The advocacy that takes place within the CCMP, which can be seen as an alternative health provider, is akin to the advocacy (i.e. the act of volunteering and political advocacy) that occurs within the free clinic at Our Lady Guadalupe Free Clinic. Those that have volunteered at the OLGFC and CCMP can be seen as not merely committing acts of charity, but acting as advocates for humanity as part of a humanitarian mission (Tiedje and Plevak 2014, 5). For those that volunteer at these two associations, it’s not just about “giving back”, but understanding that those that are uninsured are human beings that deserve to be treated with respect. Volunteers at both organizations see the right to health as something that must be advocated for and that the healthcare structure in the U.S. is a broken system that needs to be fixed in order to be able to include all groups of people (Tiedje and Plevak, 2014, 5-6). The volunteers at the CCMP do all in their power to give the patients the necessary treatment.

Advocacy is an incredibly strenuous and ongoing act of volunteering that is specific to the CCMP. However, while it may cause worry for some volunteers it can be seen as immensely rewarding and gratifying for others. Two volunteers that feel this way are Rosa\textsuperscript{15} and Joan\textsuperscript{16}. Rosa is a thirty-eight year old single mother whose parents come from Columbia. Though she is an American-born citizen, she is appalled at the measures that certain immigrants have to go through in order to obtain certain health services. As such, she does whatever she can in order to ease their hardships. Joan is a seventy year old retired nurse who used to specialize in geriatrics. In Joan’s perception, she has witnessed too many unnecessary deaths and suffering at the hands of the insurance bureaucrats that hide behind forms and numbers. Seeing the hardships that these patients go through, they do all they can to counteract the doxa by having their own opinion (orthodoxy) which they try and relate to others:

\textsuperscript{15} Rosa will be the alias utilized to refer to one of the advocates that I encountered during my time at the CCMP.
\textsuperscript{16} Joan will be the alias utilized when talking about one of the advocates that I met while at the CCMP.
Rosa: “All I have to do is ask myself, what if it were someone I knew and loved? I mean, my parents could have been in their situation. And yes, it’s a very tough and demanding job; because that’s what it feels like sometimes. It doesn’t feel like I’m volunteering, it feels like I’m working…”

Joan: “You are working. You’re working to save a life. These people don’t need to die. They don’t…” the elderly woman interrupts.

Rosa: “Yes it’s stressful. I have to go to appointments, and go with them to the diagnostics centers. And translating! The translations are difficult even for a native Spanish speaker like myself. And there aren’t enough advocates that speak Spanish, and there are a lot of Spanish speaking patients. Sometimes I feel like I’m being spread thin at times,”

Joan: “Well if you don’t do it, who else will? And if I don’t do it, who else will? Those people don’t have options. It’s tough but it has to be done. If we say no, what’s to say that these people will live another year, let alone another month. They’re people like you and I. They don’t need to suffer!”

Advocacy is an incredibly intricate and unique attribute of the Coalition of Concerned Medical Professionals. Though it is not a role that every volunteer can, or even wishes to take on, the task produces an array of emotions. However, the manner in which the volunteers chose to deal with the health system that they must maneuver is a testament to the volunteers that continually act as an advocate.
Chapter Seven: A Doctor and Their Patient

One of the closest relationships that a person may form is with their doctor, or any other healthcare professional for that matter. This relation would ideally contain a sense of ease within the encounters. In an idealized scenario a patient and the doctor would have a harmonious relationship with one another. The rapport between the doctor and the patient may even contain levels of comfort and trust. The patient could feel as if the doctor is doing everything within their power to alleviate any physical ailments that they may have. Ideally a patient should also be given the proper time during medical, or any other, examinations as well as the upcoming procedures. In a model situation a patient would feel as if their physician and their healthcare provider is actively being attentive to their symptoms, and acting in the best manner possible. In an optimal case a patient would not feel as if they are not properly being correctly taken of, their concerns are being disregarded, or as if they are merely an object. However consulting physicians are met with realities that do not coincidence with such idealizations (Law 2004, 51), as in current times physicians no longer view the patient as a being that is to be treated but as a body part that is to be fixed (Davenport 2000, 311). This objectification of the patient within medical culture, or within the medical field, is a product of the social world that they are a part of (Davenport 2000, 313).

During my time at the Coalition of Concerned Professionals I witnessed many types of interactions between the volunteering physicians and the patients at the organization. I made sure to take note of how the way in which the doctor created relations with the patients contributed to the realities (Law 2004, 29) that they worked, and volunteered in (i.e. the medical field and setting of the CCMP). I took note of the perception of uninsured patients by the volunteering physicians of the CCMP in an effort to understand if they agreed with certain opinions and social stigmas about uninsured patients (i.e. the characterization and stereotype of someone who would not have insurance and access to healthcare treatment, or the social stigma that those that do not have access to healthcare treatment do not deserve access, or that groups that are uninsured are in some way lesser than other members of society). I observed volunteering doctors that would stay
and treat as many patients as needed, while other volunteering doctors would donate two to four hours of their time or treat a certain number of patients. Other doctors that would treat patients for the CCMP would only do so on the basis that the uninsured patient would set up an appointment and visit the doctor at their own private practice.

As such the stories of the different volunteering physicians that I encountered during my time at the CCMP, and via the accounts of other volunteers, exemplify the different types of physicians that can be found associating with the CCMP and most importantly within the field of the CCMP. The experiences of these volunteering physicians also exemplify the challenges that physicians face when navigating a healthcare system that is dominated by economic interests, and how their role is defined by the economically commodified system in which uninsured patients are considered to be “failed consumers” (Rivkin-Fish 2011, 186). For instance the difficulties that the physicians face in volunteering due to time constraints imposed by their employer, their own private practice, or possible conflicts with insurance agencies. The accounts of the physicians also show how in the end even the physicians are entangled in the social web that is created by medical knowledge and power (Davenport 2000, 312). Furthermore, the manner in which the volunteering doctors interacted with the uninsured patients that they treated at the CCMP is important in understanding the opinions that the volunteering physicians have about uninsured patients, as power relations are “reproduced in miniature in doctors’ examination rooms”(Davenport 2000, 313).

It should be noted that these physicians in the end are scientists that have their own way of thinking and acting, as well as their own set of moral values. Many times while conducting their work, these physicians are put into places of extreme difficulty that make them compromise their moral character. As a result of their practice, their work, and their beliefs these doctors in turn produce scientific knowledge (Law 2004, 19) that are occasionally utilized by agencies of power17, and reveal the ways in which physicians “act as agents of social control” (Davenport 2000, 313).

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17 A more precise example of such an instance will be described when discussing Dr. Alexandra Tate in an upcoming section.
The CCMP is in a constant state of recruitment, primarily for doctors and other medical physicians. As physicians play a key role in what the organization sets out to do, it is crucial that the CCMP recruit as many doctors as possible to treat, and help, as many patients as they can. In total there are only approximately eight medical professionals that are currently associated with the organization. The doctors volunteer their services and skills in specific ways approximately once a month. As it stands, Dr. Smith is the primary physician in the monthly GMS. Dr. Carter\textsuperscript{18} is the primary physician in the GPS, and there are multiple dentists that participate at their own practices during a GDS. The physicians that occasionally volunteer at the CCMP maintain their own thoughts on the U.S. healthcare system and their position in it. These physicians also have their own perceptions of uninsured patients.

**The Doctor, the Insurance Agency and the Patient as the Object**

While at the CCMP I witnessed many different scenarios where physicians would either end up volunteering with the organization, or dismissing it and its aims entirely. On one occasion I accompanied Beth on a visit to a doctor’s private practice. Beth had enlisted the help of a fellow volunteering physician to speak with the doctor who owned the practice. During this “pitch” of sorts Beth explained how the CCMP fights for healthcare to be a universal right, the current conditions in the U.S. healthcare system, and how the doctor could help the organization fight against the injustices that happen in such a healthcare system where economic interests shape the structure of the system.

The accompanying volunteering physician then also talked about what the CCMP is and the ways in which the organization helps many people that would otherwise not be able to seek treatment. The volunteering physician also told the fellow doctor about their own personal experiences during their time in the organization. It was in visits like this that Beth would attempt to recruit doctors. Doctors were also recruited during literature tables all around the city,\textsuperscript{18} Dr. Carter will be the alias utilized for the actual consulting podiatrist that I encountered during the CCMP’s podiatric sessions. I encountered Dr. Carter a total number of three times at the CCMP’s Brooklyn location during the time I was there gathering and compiling my data.
or when the CCMP would set up a literature table at a medical fair, or other activities and events. However, it was as this attempt at recruiting a doctor, that particular stigmas about the uninsured patient were brought up:

Beth: “As you probably know there are various problems in the healthcare system, it’s a tragedy really. People are dying unnecessarily all because they can’t afford to see a physician. And that’s inhumane, healthcare should be a right not a privilege.”

Dr. Alan: “Well, that’s a touchy subject with a lot of parts to it.”

Beth: “What parts in particular?”

Dr. Alan: “Well...not to sound stereotypical but...I’m sure these patients that visit the CCMP are of a certain...type.”

Beth: “Excuse me?”

Dr. Alan: “It’s a statistical fact that uninsured patients that seek free healthcare are of a...certain caliber. I’m not saying they’re necessarily bad people, but that they have this stereotype for a reason. They act a certain way. It’s different when you treat a patient with insurance. There’s a different process, a different atmosphere.”

This discourse relates to the mentality that allows for the reproductions of stigmas and power relations (Davenport 2000, 314). As it is a hope that the volunteering physicians of the CCMP will withhold judgement of the uninsured patient, and instead focus on developing quality treatment, it was agreed upon by Beth and Luz that Dr. Alan would not be a good fit for the organization. Volunteers at the CCMP note that the physicians that they encounter and attempt to recruit possess an awareness of the “power dynamic at play in medical practice” (Davenport 2000, 321).

Upon meeting Luz and Elizabeth I was flooded with many stories of the previous patients that they had encountered, and the many struggles that followed in regards to contact with either insurance agencies or corporations in the healthcare sector, as well as the realization that they must navigate the U.S. healthcare system that is riddled with social stigmas of uninsured patients. I also heard stories in which the patient was treated as a simple object that needed to be dealt with in the most cost-saving way possible. Often times, the insurance agencies and

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19 Dr. Alan will be the alias utilized for the actual medical doctor that I encountered during Beth’s attempt at recruiting the physician. In total, I encountered Dr. Alan only once during my time with the CCMP during my fieldwork and internship.
corporations utilized doctors to deliver a punishment to the body (i.e. withholding certain healthcare services or treatment) to those that could not afford their services. In certain situations, agencies of power have utilized the physician to deliver the appropriate “punishment”. The physician can be viewed as taking over the role of an executioner, and deliverer of pain (Foucault 1975, 11) in these drastic situations.

It should be noted that the objectification of the patient is not a new phenomenon. Bourdieu notes that it was during the span of the 18th century where the discourse among the physician and the patient change dramatically. Instead of asking the patients questions like: “Can you tell me what is the matter with you?”, physician now asked the patient: “Where does it hurt?” (Davenport 2000, 311). This dominant pattern within modern medicine of seeing the patient as a mere case or condition instead of a human being is referred to as the medical gaze.

The most startling case that I personally heard which dealt with treating the patient as an object concerned a woman that had trouble with blood circulation in her legs. The story, which was narrated by Luz, was told to me during my very first day at the CCMP in an effort to portray how insurance agencies and other businesses in the healthcare sector were treating these live beings as nothing more than figures on a spreadsheet:

Luz: “It’s very important that the patients that walk through our doors feel treated like they are no different from anyone else that receives treatment, because the fact is they aren’t.”
Jennifer: “I’m sure some patients have felt differently. Even though this is a volunteer organization, surely some doctors have treated them differently.” I contradicted her statement and probed for more information.
Luz: “Sometimes. But we do everything that we can to stop that from happening. These are people, not objects. Although there have been cases where that was the issue.”
Jennifer: “Can you explain a specific case in which that was the instance?”
Luz: “Well just recently we dealt with a woman and her insurance company. We even had to file a lawsuit and go to court. And that takes up a lot of CCMP resources.”
Jennifer: “What did you have to go to court for?”
Luz: “Basically, and this is just a very brief summary of all the processes and red-tape that this woman and the CCMP had to go through, this woman was not feeling as well as she should have been and so she went to the doctor. Apparently she had some circulatory issues within her legs and needed treatment in a particular kind of air-chamber, or something that would sort out these particular circulatory problems. And so, when she went to her insurance company
and said: ‘This is what I need to be able to walk and keep my legs’, the insurance company said ‘No’.”

Jennifer: “But how can an insurance company just say no? Isn’t that what an insurance company is there for? To pay for procedures like this?”

Luz: “Well that’s what one would think but it isn’t what always happens. Do you know what the insurance company offered to do to this woman instead of giving her the circulation therapy in that air-chamber?”

Jennifer: “What?”
Luz: “They offered to pay for amputation.”

Jennifer: “They wanted to cut off her legs?” I asked as I was surprised at the events that had just been described to me. Surely Luz must have been remembering the facts incorrectly.

Luz: “Yes.” She said without hesitation and no further explanation.

Jennifer: “Did they offer a reason?”
Luz: “When it all came down to it, it was simply cheaper and easier for this insurance company to just chop off this woman’s legs instead of giving her the circulatory therapy that she needed.”

Jennifer: “What happened afterwards? Was she able to get the therapy treatment?”
Luz: “Well, as this woman simply wanted to keep her own legs, she got into contact with us. From there we got into contact with lawyers that are affiliated with and supporters of the CCMP, and we went to court.”

Jennifer: “I hope you were successful in this certain case...”
Luz: “This time we were, yes.”

This depiction of how agencies of power exert bodily punishment in an attempt to retain their control was not the only startling story I heard. Unfortunately Luz and Elizabeth had multiple stories of patients, both with and without healthcare insurance, in which the patients were treated as a pawn or another object that needed to be dealt with in the most cost-effective manner. When dealing which healthcare insurance companies, or other establishments within the private sector, it appeared that the benefit of the patient themselves, the subject not the object, was not taken into consideration even once.

The doctors, dentists, and nurses that volunteer their time at the CCMP generally concede in the opinion that healthcare should be a universal right and not limited to those within the top tiers of the social and monetary stratifications that are currently in place that define individuals (Foucault 1975, 18) as worthy or unworthy of certain services. However there are particular healthcare professionals that contribute, either knowingly or unknowingly, to the social divisions within the healthcare system.
Once case in which a physician contributed to the social divisions within the healthcare system concerns a former volunteer at the Coalition of Concerned Medical Professionals. This general practitioner, who shall go by the name of Dr. Alexandra Tate, entered the CCMP location on a Monday afternoon to drop off a donation. Dr. Tate also wished to be filled in on the CCMP’s progress, as well as the organization’s upcoming events. When I first encountered Dr. Tate I introduced myself and asked about her past involvement with the CCMP. I also asked her about her current association with the organization; I thought that perhaps she could also conduct general medical sessions, as the organization currently needed a general practitioner to volunteer their services. However as I began to ask her questions, I learned that this was not the case and she did not wish to volunteer her services.

Dr. Tate had come to know the organization a number of years ago when the CCMP was out conducting a literature table and attempting to sign-up new volunteers, and try to collect monetary donations. Intrigued by the notion that healthcare should be a universal right, Dr. Tate began to continuously make monetary donations as she could not volunteer her skills or services due to a lack of availability.

As the years passed the hospital in which Dr. Tate was employed was shut down due to a lack of funding and she was left without employment. Worried by her difficult predicament, Dr. Tate agreed to take employment from a healthcare insurance company and act as a consultant. On her very first assignment Dr. Tate was sent to a job-site in order to evaluate the conditions of a particular company’s workers. The workers of this company had been complaining that their work environment was causing physical ailments. As Dr. Tate readied herself to exam and diagnosis her patients, she was told by the insurance company that she was legally not allowed to diagnosis certain ailments, nor allude to the fact that the workers could possibly have a certain illness.

Surprised by what she was told she could and could not do, Dr. Tate initially began to refuse the demands of the insurance company. However, she was silenced by the legal

20 Dr. Alexandra Tate will be the alias utilized for the actual general practitioner that I encountered while at the Coalition of Concerned Medical Professionals. I encountered Dr. Tate only once, and she agreed to discuss her past discretions with me as long as I would change her name within my thesis.
documents which she had signed upon employment. Dr. Tate conducted the medical examinations and was in an internal ethical battle as she conducted each one. It is also an example of medical gaze at play. However, the consulting physician had issues with being an agent in which agencies of power exercised their control. She describes the process as:

“an overwhelming act of deceit. Lying. That’s what it was. If someone had a severe illness that was being caused by their job I could not legally tell them. If that would happen, who knows what type of force would’ve come down on me by that insurance company. I didn’t have a choice...but I still hate my part in helping that company lie to so many people. I wasn’t a doctor when I was working there. I was just...a liar.”

The internal struggle in which Dr. Tate had to deal with eventually caused the physician to leave her newfound employment after only a couple of months. Dr. Tate states that she felt like a hypocrite with each evaluation that she was sent to conduct, and began to question not only her career but her entire moral being. Unfortunately, I did not come into any further contact with Dr. Tate during my time at the CCMP.

Although the scenario in which was described in relation to Dr. Tate and her particular situation is a specific case, it is a commentary upon how the power of enterprises and insurance companies try to control the medical enterprise by manipulating the body of those that find themselves at the lower sphere of the social stratifications.

**Dr. Carter**

Born and raised within the Canarsie neighborhood, Dr. Carter can be described as an eccentric, fast-talking, yamaka-wearing podiatrist that simply loves to treat patients. The sixty year old podiatrist with his small, gold round-rimmed glasses has many ties to the Coalition of Concerned Professionals. In fact, the CCMP owes an immense amount of gratitude to Dr. Carter for multiple reasons. One of the reasons that the CCMP owes it gratitude to Dr. Carter is the fact that the CCMP now occupies Dr. Carter’s former podiatric facility. Back in the year 2009, Dr. Carter informed the organization that the building he was currently utilizing for his private
podiatry practice was soon to go up for sale. As the CCMP was looking for a permanent location that would grant the organization stability and more opportunities to grow, the CCMP jumped at the chance to own their own property. Dr. Carter gave the organization a fair price and the ability to have something that they have never previously had.

When talking to Dr. Carter, I posed to him the questions that I had inquired of other healthcare professionals that I had met during my time at the CCMP. I inquired as to how he first heard of the organization, why he began and still continues to volunteer with the organization, and his general thoughts on the current healthcare situation within the United States and uninsured patients. The discussion with Dr. Carter proved that he had made his own opinion (orthodoxy) that went against the popularized opinion (doxa) of what an uninsured patient is:

Dr. Carter: “The healthcare here? Pfft!” he exasperates in an exaggerated manner.
Jennifer: “What have been your personal experiences with it?”
Dr. Carter: “Unfortunately not the best. No one should die because they have to pay for help. And you see the people behind these companies and they just don’t care. They don’t care who lives and dies they just care that they get paid!”
Jennifer: “Have you ever personally encountered a problem with insurance agencies coming in between an agent and their treatment?”
Dr. Carter: “Well, I personally haven’t but I’ve heard the stories. Especially working here. And even though I’m a podiatrist doesn’t mean that health issues pertaining to podiatry cannot lead to a patient’s death. And you hear these stories and they’re just heartbreaking. It’s saddening.”
Jennifer: “But you try and change it. You volunteer when you can.”
Dr. Carter: “Yes. I do. And I tell myself that every person that I help makes a difference. Even if I don’t always believe in that myself.”
Jennifer: “But you do make a difference. You’re here volunteering and from what I hear, you see as many patients as needed. You don’t have a limit of patients that can be seen, or a certain amount of hours that you won’t go past. Other doctors only ‘help’ so much.”
Dr. Carter: “Someone has to. Why not me?”
Jennifer: “What’re your thoughts on uninsured patients? Are they different?”
Dr. Carter: “Uninsured or insured, patients still have problems dealing with healthcare. I don’t care who you are, where you’re from, or anything thing else. Everyone deserves the right to healthcare. But that doesn’t mean everyone gets it. But when I’m with a patient, no matter if they have insurance or not, I treat them with the same amount of respect as I would anyone else. They’re a person. They’re not defined by whether or not they can pay for a service that should be free.”
Jennifer: “I also notice that you’ll see as many patients as needed, or attend a GPS.”
Dr. Carter: “I’m here for a reason and that’s to treat patients. I’m not going to them any differently than the patients that come to my private practice and pay for services.”

Although Dr. Carter did not personally have any problems with hospitals, insurance agencies, or any other corporations affiliated to medical healthcare, he was adamant about doing all that he could to alleviate the stress and pain to the many patients that were affected by certain rules and legislations. As a volunteer that has given much of his time, effort, as well as donations to the organization, Dr. Carter is an important part of what the organization was, continues to be, and strives to become.

**Dr. Smith**

The monthly medical sessions that are conducted by the CCMP are one of the most important, and indeed most life-saving activities of the organization. Throughout the years many doctors have volunteered their time, their skills, and multiple resources to the organization in an effort to provide uninsured patients the best care possible. Though the doctors that volunteer are constantly in rotation and ever changing, their impact is always felt. The current doctor that participates within the Coalition of Concerned Medical Professionals monthly general medical session is gastroenterologist Dr. Smith.

The gastroenterologist originally hails from Houston, Texas and has his own private practice in New York City. Dr. Smith also conducts multiples research projects and is continually glued to either his laptop or his cellphone. While observing Dr. Smith’s mannerisms while treating patients, as well as his answers to the inquires I raised during my interview with him, multiple conclusions can be made.

While conducting exams with the patients during the monthly medical sessions he is very present in the moment, and is genuinely concerned about the patient’s wellbeing and does everything within his power to help the patient while he is there. As soon as Dr. Smith leaves the examination room his demeanor shifts. His focus is now upon the research that he is conducting.
back in Texas. He immediately starts looking at his cellphone and laptop as his attention is now on another endeavor. Also, Dr. Smith is restricted by time since he has many tasks to tend to.

Though he has been volunteering with the CCMP for some years now, he still wishes everything to be related to his secretary and will not guarantee to be the consulting doctor on the next month’s general medical session unless there are a certain number of patients to see as he does not wish to “waste his time”. As an actor that navigates the healthcare system, Dr. Smith is a good example of an actor that both adheres to and goes against the doxa. While volunteering a certain amount of his time to the CCMP, Dr. Smith is working against agencies of power that seek to retain control over the collective body. However, by treating uninsured patients via the medical gaze and limiting the interaction that is spent with the uninsured patients in order to give more time to insured patients, he reaffirms the doxa and maintains control of the body that agencies of power have.

While talking to Dr. Smith I tried to gage his honest opinion about the current issues within healthcare, his reasons for joining the Coalition of Concerned Medical Professionals, his perception of uninsured patients, and his overall views on the organization:

Jennifer: “So, how long have you been volunteering with the CCMP?”
Dr. Smith: “Too long.” he laughs.
Jennifer: “How did you first come into contact with the organization?”
Dr. Smith: “If I remember correctly, they had a literate table at a medical convention that I was at and... the rest is history.”
Jennifer: “So why do you continue to volunteer with the organization?”
Dr. Smith: “Well...I guess I feel some sort of obligation. Although I’m very busy: I have my own practice and I conduct research with multiple programs back in Texas where I’m from.”
Jennifer: “Obligation? Do you mean to those that do not have healthcare insurance or an obligation to the organization?”
Dr. Smith: “I’m not sure I understand your question exactly.”
Jennifer: “I guess I’m just inquiring as to why you’re volunteering at this particular organization. As well as your opinions on the current healthcare situation, and uninsured patients.”
Dr. Smith: “Well insurance coverage is entirely too much. Too much of a doctor’s paycheck goes towards that. In fact, if a student is unsure about becoming a doctor and they ask for my honest opinion...then I would steer them away from the medical field. It’s just not worth it, I feel.”
Jennifer: “Making a difference and potentially saving life is not worth it?”
Dr. Smith: “You don’t always save lives. In fact it can be a hindrance at times but...that’s the life I’ve chosen and it’s too late to exactly change it now.”
Jennifer: “What about your opinion on uninsured patients?”
Dr. Smith: “Well that's a tricky subject that has many different parts to it. Not even insured patient is the same, not everyone has the same reasons as to why they don’t have healthcare insurance. It’s a complicated issue. I guess if I’m being completely honest I guess I am not 100% behind the thought of everyone receiving healthcare. Some don’t even try and make the changes necessary to get it.”

When speaking with Dr. Smith, I could not come to a conclusion about his character or garner his honest opinion about multiple issues within the healthcare sector. He was willing to volunteer with the organization, but at the same time would seem irritated with the amount of time the organization would request of him. My confusion of Dr. Smith also was due to the fact that he continued to volunteer at the organization, while holding this notion (that can be perceived of as negative) of what an uninsured patient is.

While at the Coalition of Concerned Medical Professionals I heard the tales of, met in person, and witnessed first handedly doctors that were a contradiction. These medical professionals would act one way, yet claim to feel another. While stating that they felt sympathetic to those that were unnecessarily suffering at the injustices within the U.S. healthcare system, certain doctors would knowingly contribute to the social stratifications, stereotypes, social stigmas, and the continual injustices that kept those same people that they sporadically helped in ailing state. However, there were the medical professionals that were openly outraged, and still volunteered as much as possible, hoping that their small act would make a difference that someone so desperately needed it. These multiple and conflicting opinions both help create and dismantle the stigma of the uninsured patient.
Chapter Eight: Conclusion

Throughout this thesis multiple points have been made in the exploration of medical encounters between doctors, volunteers, and uninsured patients in a particular setting. This setting, The Coalition of Concerned Medical Professionals (CCMP), is particular as it is not a free healthcare clinic but offers free healthcare services multiple times throughout the year. It is also an organization that has the aspect of acting as a political advocate in the enduring battle for comprehensive healthcare for all.

The points and arguments within this are based on the collection of data and information from April 2014 to July 2014 in the Brooklyn borough of New York City via the use of participant observation of the multiple activities conducted by the CCMP. The points within this thesis have also been created via the use of active participant listening, as well as the use of many different forms of interviews. I have noted how during the collection of this data I faced internal struggles as I acted in a double role as a volunteer/intern and a researcher. I also take note of wondering if my role as a volunteer/intern superseded my role as an anthropologist, as well as my worries about the ethical implications of my double role in the organization.

From the data I have collected in my attempt to understand the medical encounters between doctors, patients, and volunteers, I have written a thesis that has shown multiple aspects of the ways in which volunteers and doctors not only interact within the CCMP as a field but also lend themselves to the creation of stereotypes and stigmas of an uninsured patient. I secondarily question if doctors treat the uninsured patients of the CCMP differently; if they treat uninsured patients with the same respect and regard as they would a patient with healthcare insurance. I also make note of some internal struggles that the volunteers of the CCMP have in regards to their participation in the organization. As the perception of the uninsured patient is related to various thoughts and opinions, mostly associated with the negative, it is crucial to understand how doctors and volunteers interact with such patients; especially as the current U.S. healthcare system, which aims to include everyone, excludes certain people from gaining access to healthcare insurance.
In this thesis, certain themes are predominant:

**The containment of power by agencies/institutions:**

As noted multiple times within the thesis, the U.S. healthcare system has transformed healthcare and its services into a commodity that seemingly values monetary profits above all else, even human lives. As such, agencies of power (i.e. healthcare insurances agencies and corporations in the healthcare sector) strive to retain their power over those that seek treatment. By utilizing Foucault’s notion of *biopower* to contextualize situations in which patients have been treated as objects, I not only depict how agencies have manipulated the body of the patient, but I illustrate the reality of agencies and institutions of power going to great lengths to keep their control. I also state that agencies of power utilize physicians in retaining their power, like that in the case of Dr. Tate, and place restraints on the actions of the physicians (e.g. placing time restraints on how long a physician may spend with a patient).

**The CCMP as a field:**

By viewing the CCMP as a complex *field*, it helps us to understand the production and maintenance (Bourgois and Schonberg 2007, 28) of the stigma of the uninsured patient. In this thesis I give the reader a small glimpse into the history of the U.S. healthcare system. I also give the reader the full history of the CCMP to illustrate how the CCMP has been produced as a field as a response to the issues and constraints in the healthcare system. I also state that the CCMP is a field with many aspects. Besides their political advocacy, the CCMP strives to be a setting where uninsured patients are treated no differently than insured patients. The hindrance of these injustices that take place in the healthcare sector, in relation to the restriction of services and treatment, hopefully limits the creation and reproduction of stereotypes and stigmas of the uninsured patient.
The perception of the uninsured patient by volunteers:

The CCMP adheres to the notion of healthcare being a universal right and is something that they ask all CCMP volunteers their opinion on before becoming a volunteer. The CCMP aims to be an environment where all volunteers have the perception that the uninsured patient is no different than any other patient. The CCMP also fights for a comprehensive healthcare system. However, the opinions of the volunteers at the CCMP do not always go against the popularized opinion of the uninsured patient as I have shown (e.g. Harry’s opinion on the patient that he is the acting advocate for).

The perception of the uninsured patient by doctors:

As the doctors of the CCMP are crucial to the planning of the treatment necessary for a patient’s road to recovery, the manner in which they treat and perceive the uninsured patient is important. By using Foucault’s notion of the medical gaze I have shown how physicians have been taught to see patients as an object that is to be fixed, instead of a human being that is to be treated. From this, certain doctors either continue to view the patient (both insured and uninsured) as nothing more than a body part that needs fixing or sees the patient as the human being that they are. In this thesis I highlight the perceptions of uninsured patients by doctors, and note if they agree with the doxa of the uninsured patient or have created their own opinion (orthodoxy) of uninsured patients.

The experience of uninsured patients:

Certain patients that I have encountered in the field of the CCMP are aware of the stigmatization of what it means to be an uninsured patient. While notions of being a second class citizen is one concept of what it means to be an uninsured patient, there were other feelings of discrimination, judgement, and shame attached to it. While most of the patients at the CCMP were aware of the stereotype and social stigma of what it meant to be someone that does not have access to healthcare insurance or its services, I note how certain patients unknowingly perform
acts that aid to the creations of the social stigmas and stereotypes that the volunteers at the CCMP are working against.

While at the CCMP I took note of multiple actors in the field of not only the organization, but the overarching medical field. As the interactions between a doctor and patient can be viewed as a kinship of sorts, it is important that all aspects of the doctor-patient relationship be researched. By researching the aspect of the uninsured patient and its effects on the interaction between the doctor and the patient, it allows us to begin to understand the specific medical encounters that occur between the two actors. By researching the perception a treating physician has of an uninsured patient, it not only reveals the modes of domination that have been produced as a result of the commodification of healthcare insurance, services and treatments in the U.S., but can allow further discussions on whether or not the doctor is a hindrance in the treatment of an uninsured patient due to preconceived opinions of the uninsured patient. In this regard, Anthropology can be used to observe the interactions and potentially aid those in the public health sector in the creation of new policies.
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