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Immigration and Medical Anthropology

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Immigrants trying to negotiate the US medical system give testimony to the truth in Virchow's famous declaration, "All medicine is politics." Viewing immigrants as outsiders who are simultaneously insiders, the larger society often questions their use of medical and other social services. The issue of medical services for immigrants and citizens alike, at least in the United States, is open to such debate because there is no guaranteed "right" to medical care. Even though citizens may feel an entitlement to medical care, many are unwilling to grant this to immigrants. As a consequence, immigrants seeking medical care face restrictive policies, financial tests, and citizenship requirements. Moreover, immigrants often enter the labor force at the bottom, where low incomes, lack of medical insurance, and little available time present obstacles to their use of medical services. In short, immigrants are disadvantageously embedded in a political economy of health care characterized by pervasive structural inequalities (Farmer 1999; Morsey 1996; Whiteford 1996). It is a challenge for anthropologists, particularly those taking a critical approach (Lock and Scheper-Hughes 1996), to explore the influence of culture on immigrants' use of US medical

services without minimizing the tremendous role these structural factors play in the lives of immigrants. This chapter highlights several important problems that occur when immigrants interact with the US medical system (also see Hirsch, Chapter 8). I will draw on my own research and that of others for examples of issues that arise from the confrontation of immigrants' cultural beliefs with the receiving society's medical beliefs and practices, the stigma of disease when associated with particular immigrant groups, structural obstacles faced by immigrants seeking medical care, and the limitations of interventions at the individual instead of societal level.

Anthropological interest in immigration is both old and new. Franz Boas, the totemic ancestor of American anthropology, provided a classic example of anthropological research countering public representations of and taken-for-granted assumptions about immigrant characteristics. His research on Southern and Eastern European immigrants in the early twentieth century directly challenged existing scientific and commonsense assertions about the link between immigrants' physical/bodily structures and shapes and their moral and intellectual potential. Using the methods popular at the time, Boas measured the heads of immigrants' children (an example of the "second generation" study so in vogue in immigration research today) and compared them with the immigrants' measurements. He found that the second generation did not resemble the immigrant generation in head shape. As Kraut has noted, "Boas concluded that nutrition and other aspects of living conditions determined these 'racial characteristics' more than heredity" (Boas 1911a; Kraut 1994). A few years later, in the 1920s, the Mexican anthropologist Manuel Gamio carried out investigations into the life and working conditions of Mexicans in the United States (Gamio 1930, 1931). The poignant narratives he collected from Mexican workers provide compelling evidence for the harsh, unhealthy working conditions they endured and the social and political barriers to integration they encountered. (See Chavez [1992] for a discussion of contemporary living and working conditions for farm workers in Southern California. See also Goldsmith [1989]).

Despite these early examples of interest in immigration, anthropological research on immigration waned, perhaps because of the massive reduction in immigration during the Great Depression and World War

II (Pedraza 1996). Just as influential was anthropology's professional identification as the science of the *Other* (read "primitive," "less technologically advanced," "less complex political organization"), of non-Western cultures and societies that had to be "salvaged" before they passed away as a result of the putative, homogenizing march of modernity. An anthropological interest in immigrants returned in the latter decades of the twentieth century, corresponding to worldwide increases in the transnational movements of refugees and people seeking economic opportunities (Brettell and Hollifield, eds. 2000). In the United States, immigration flows have increased steadily since the mid-1960s, reaching about one million legal and undocumented immigrants a year by the end of the twentieth century and into the early twenty-first century (Pedraza 1996). The movement of people has not affected only the United States; it has had global repercussions (Castles and Miller 1998).

Immigration has given anthropologists a window into the ramifications of people's crossing national borders. As the world experiences what has become glossed under the concepts of globalization and transnationalism, anthropologists, and many others, want to understand the implications of the rapid and increasingly efficient movement of people, capital, goods, and information across increasingly porous national borders. In many ways, these movements are constructing a world of linkages, bridges, connections, and hybridizations, all of which are forcing a re-thinking of "the national order of things" (Malkki 1992). At the same time, immigrants often receive an ambivalent welcome when they cross those borders (Chavez 2001). Ground zero in this ambivalence frequently centers in the domain of medical care (and its utilization) and competing, or at least different, cultural beliefs surrounding health, illness, and well-being. In sum, focusing on immigrants can throw into stark relief many theoretical issues central to medical anthropology and anthropology in general.

IMMIGRANTS AND CULTURES CROSSING BORDERS

The movement of people has implications for the physical and mental health of those who move and those among whom they establish themselves. The history of European contact with native peoples in the Americas provides a tragic example of this. The indigenous Americans suffered massive population declines after Europeans

arrived in the New World. They were felled not so much by strength of arms as by the silent, unseen germs and viruses brought by the Europeans and their animals. American Indians had no natural immunities for many European diseases, even children's diseases considered relatively harmless, such as measles, swine flu, and chicken pox. The loss in human life is almost beyond our abilities to imagine. By some estimates, as many as 90 percent of certain American Indian populations died after a succession of epidemics and plagues, sometimes before they even met Europeans. Disease went ahead of the Europeans, clearing the land of much of the native population and weakening its capability to withstand the invaders (Kraut 1994). Unfortunately, miners, colonists, and missionaries (and even anthropologists) who come into contact with people in remote areas of the world, such as the Amazon, continue to introduce deadly epidemics to natives (Chagnon 1997). In the Americas, ironically, the Europeans acquired valuable medicinal knowledge from the native *shamans,* or medical specialists, who were very adept at the use of indigenous plants to treat illnesses. Hundreds of indigenous drugs have been listed in the *Pharmacopoeia of the United States of America* and the *National Formulary* (Kraut 1994).

Today's immigrants are less likely to come from Europe and the industrialized nations than from less industrialized countries in Asia and Latin America. Anthropologists have long studied in the places where today's immigrants were born. They have written extensively on practices of folk healers, the use of folk medicine, the nature of folk illnesses, and indigenous beliefs about the body and what it means to be healthy (Rubel and Hass 1996). Not surprisingly, immigrants bring with them beliefs, behaviors, fears, prejudices, values, and established assumptions about both the physical and spiritual worlds that may not correspond to dominant cultural realities in the society at large. This is especially true when their beliefs and cultural assumptions come into contact with the culture of biomedicine.

Anthropologists speak of biomedicine as a cultural system because, like religious systems, ideological systems, and even common sense, biomedicine has the "capacity to express the nature of the world and to shape that world to [its] dimensions" (Geertz 1973b; Rhodes 1996:166; see also Clifford Geertz's [1973b, 1983] discussions of cultural systems). The ethnomedical systems of immigrants can differ from biomedicine

in fundamental ways. Modern biomedicine evolved from the Cartesian premise of a mind-body dichotomy. As Lock and Scheper-Hughes (1996:58) noted, in biomedicine, "body and self are understood as distinct and separable entities; illness resides in either the body or the mind.… By contrast, many ethnomedical systems do not logically distinguish body, mind, and self, and therefore illness cannot be situated in mind or body alone."

For some immigrants, the spiritual and the physical are linked together and form the basis for understanding many illnesses, their symptoms, and their cures. Too often, immigrants find themselves facing problems associated with what have become commonplace, postmodern dilemmas. Their health-related beliefs and practices can place them on a collision course with the US biomedical system. Immigrants may have culture-specific beliefs about health, illness, and wellness and culture-specific expectations of patient-healer interaction. When immigrants suddenly arrive at a US hospital emergency room, their beliefs may not be familiar to attending physicians and staff. This is especially true for folk illnesses or culture-bound illnesses.

In their book, *The Culture-Bound Syndromes,* Simons and Hughes (1985:475–497) list 158 illnesses, but even this is only a partial list because every culture, past and present, undoubtedly has one or more culture-bound illnesses. Table 7.1 suggests but a few of the many illnesses typically unrecognized by practitioners of biomedicine but pervasive among the cultures of origin of many immigrants in the United States. Associated with such illnesses are notions about appropriate curing rituals and practitioners (the need, for example, to deal with the spirit world), as well as traditional epistemologies about the relationship between the physical body and the spiritual self.

In *The Spirit Catches and You Fall Down,* Anne Fadiman (1997) has provided a poignant example of how cultures can collide when immigrants seek medical care. This is the story of a Hmong family in Merced, California. One day Lia, a young child born in the United States, suddenly began experiencing seizures. Biomedicine understands this as epilepsy, but the parents attributed this to Lia's soul leaving her body when she was frightened by the loud noise of a closing door. What developed over many years of interaction with doctors, nurses, other medical personnel, and social workers affiliated with a

TABLE 7.1

Selected Folk Illnesses Found among Immigrants in the United States

Folk Illness	*Country of Origin*	*Symptoms*
Aire ("vapors")	Peru	Eczema, dermatitis, epilepsy, convulsions, hysteria, paralysis, pneumonia, gastrointestinal problems.
Amok	Malaysia, Indonesia	Violent outbursts, aggressiveness or homicidal behavior, amnesia.
Bilis	Latin America, United States	Anger and rage, nervous tension, chronic fatigue, malaise.
Boufée delirante aigüe	Haiti	Sudden aggressive behavior, confusion, hallucinations.
Cholera	Guatemala	Nausea, vomiting, diarrhea, fever, severe temper tantrum, unconsciousness, dissociative behavior.
Dhat	India, Sri Lanka, China	Severe anxiety and hypochondria associated with the discharge of semen, feelings of exhaustion, weakness.
Empacho	Latin Americans, United States	A gastrointestinal blockage caused by food clinging to the intestinal wall.
Gahsum-ari	Korea	Repressed anger causes insomnia, excessive tiredness, acute panic, fear of death, indigestion.
Koro	South China, Southeast Asia, India (Assam)	Intense anxiety that the sexual organs will recede into the body.
Latah	Malaysia, Indonesia, Japan, Thailand	Hypersensitivity to sudden fright or startle, dissociative or trance-like behavior.
Mal de ojo (evil eye)	Mediterranean, Latin America, United States	A fixed stare from an adult causes fitful sleep, crying without cause, diarrhea, vomiting, fever, in a child or an infant.
Mollera caída (fallen fontanelle)	Mexico United States	An infant's depressed fontanelle causes crying, fever, vomiting, and diarrhea.
Qaug dab peg (the spirit catches you and you fall down)	Hmong	Seizures (generally translated as epilepsy).
Shen-k'uei	Chinese populations	Excessive semen loss causes anxiety, panic, dizziness, backache, fatigue, insomnia.
Sin-byung	Korea	Possession by ancestral spirits causes weakness, dizziness, fear, insomnia, anxiety.
Susto, Haak-tsan, Lanti	Latin America, United States, Caribbean, China, Philippines	A frightening event causes the soul to leave the body, anxiety, irritability, anorexia, insomnia, phobias, trembling.
Taijin kyofusho	Japan	Anxiety, fear that part of the body or body odor gives offense to other people.
Zar	North Africa and Middle East	Spirit possession causes shouting, dancing, hitting the head against a wall, crying.

(Source: Adapted from Simons and Hughes 1985:475–497)

hospital in the Merced area is a story of the deep cultural misunderstandings that can arise even among well-meaning, concerned people. The story also reveals the power struggle that emerged over the parents' compliance with the doctors' advice for medical treatment.

Lia's parents feared the doctors and did not understand the purpose of the powerful drugs that had such visibly negative effects on their daughter. They were reluctant to discuss their fears with medical personnel and quietly administered her medicine in a manner they believed more appropriate, which meant not giving her the medicine sometimes. The doctors turned to Child Protective Services, which removed Lia from her parents' care and placed her in foster care. Although she was eventually returned, this had a devastating effect on her parents, who never understood how anyone could care for their daughter better than they. From the doctors' perspective, it was important that Lia's parents and the Hmong, in general, understand who has final authority over a person's medical well-being. One of the doctors who treated Lia explained why he believed that removing Lia from her parents was necessary: "I felt that there was a lesson that needed to be learned. I don't know if this is a bigoted statement, but I am going to say it anyway. I felt it was important for these Hmongs to understand that there were certain elements of medicine that we understood better than they did and that there were certain rules they had to follow with their kids' lives. I wanted the word to get out in the community that if they deviated from that, it was not acceptable behavior" (Fadiman 1997:97).

Rather than take an adversarial approach to patient-physician interactions, medical anthropologists such as Arthur Kleinman (1980, 1988) advocate that physicians ask a few simple questions of patients in order to understand their explanatory model: What do you call the problem? What do you think caused the problem?[1] Immigrant patients rarely are in a position to ask physicians and other medical personnel these questions. Their interactions with physicians are often limited because of the short time allocated for patient visits, lack of English skills, and fear that such questions might imply a lack of respect for the doctor's knowledge and authority (Chavez 1984).

The story of Lia and her family also indicates the hostile context surrounding the provision of medical services to immigrants. When

immigrants are new to an area, as the Hmong were in Merced, even highly educated people such as physicians can be totally ignorant of the historical forces behind their coming to the United States (Fadiman 1997). The Hmong were America's secret army in Laos, where they fought communists during the Vietnam War years. The Hmong believed that, in exchange for fighting, the United States would take care of them and their families. However, public opinion about the impact of immigration can color their reception, including medical care that is grudgingly given. As an obstetrician at the hospital where Lia was treated commented, "I and my friends were outraged when the Hmong started coming here. Outraged. Our government, without any advice or consent, just brought these nonworking people into our society. Why should we get them over anybody else? I've got a young Irish friend who wants to get a US education and wants to work. He can't get in. But these Hmong just kind of fly here in groups and settle like locusts. They know no shame, being on the dole. They're happy here." When appraised of the high rate of depression among the Hmong,[2] he responded, "What do you mean? This is heaven for them! They have a toilet they can poop in. They can drink water from an open faucet. They get regular checks, and they never have to work. It's absolute heaven for these people, poor souls" (Fadiman 1997:235). Attitudes of this kind form the basis of anti-immigrant movements and public policies targeting immigrant use of medical services.

As Lia's story suggests, immigrants' beliefs about health and illness can greatly affect the course of illness and even life expectancy. The work of Arthur Rubel and his colleagues (Rubel, O'Nell, and Ardon 1984) on Mexicans suffering from *susto*, or soul loss, underscores the power of belief. Believing that one is sick, afflicted, or susceptible to disease can have physical implications and determine the course of an illness. *Susto* sufferers became sicker and, in some cases, died earlier than others suffering the same health problems but not experiencing *susto*. The relationship between mind and body is a powerful one we do not fully understand.

Another example of the power of cultural beliefs was provided by David P. Phillips, a sociologist who examined the influence of traditional Chinese beliefs about birth years and their relationship to diseases (Bower 1993:293). For example, Chinese medical and astro-

logical teachings posit that people born in a fire year—which has a *6* or *7* as the final digit—do not do well when they develop heart conditions. People born in an earth year—ending in *8* or *9*—are more susceptible to diabetes, peptic ulcers, and cancerous growths. People born in a metal year—ending in *0* or *1*—do not do well when suffering from bronchitis, emphysema, or asthma. Phillips and his associates indirectly tested these beliefs by examining the California death records of 28,169 adult Chinese and 412,632 Anglo controls between 1969 and 1990. The Chinese-American death records were further divided into two groups. One group consisted of those who were born in China, resided in San Francisco or Los Angeles, and did not have an autopsy (a procedure shunned by followers of traditional Chinese medicine). The second group consisted of all the others.

The researchers found that Chinese Americans generally died earlier than Anglos if they had the ill-fated pairing of birth year and disease. When examining deaths among Chinese Americans only, those with the astrologically ill-fated pairings of year and disease died from 1.3 years to 4.9 years sooner than Chinese Americans suffering from the same diseases but not born in the "bad" years. When the two groups of Chinese Americans were compared along the dimension of traditional/modern, women born in an earth year who were more likely to hold traditional views died 3.3 years earlier than other Chinese-American cancer victims. Traditional Chinese-American women born in the metal year who suffered from bronchitis, emphysema, or asthma died 8.3 years earlier than Chinese Americans with the same illnesses but born in other years. Although this is indirect evidence, immigrants' beliefs appear to influence the severity of their illnesses. For anthropologists, this research raises more questions than it answers because it is based on aggregated data removed from individual life histories. How and why do beliefs about birth year influence illness trajectories? Did knowing the birth year of a patient affect the way others treated him or her? Did knowing the birth year's association with particular diseases affect the way patients sought and/or followed medical treatment? Does this evidence suggest that these beliefs are founded on truths that we do not perceive or understand?

"Foreign" medical beliefs can become widespread and penetrate mainstream thought. When the Chinese first came to America in the

nineteenth century, their use of medicinal plants, animal parts, and acupuncture was strange to non-Chinese and rarely sought outside Chinatown (Kraut 1994). Today, acupuncture is a subject of common discourse and is increasingly sought by non-Asian Americans. Many medical insurance programs pay for acupuncture treatment. What was once the subject of skepticism and humor is now widely accepted as an alternative, effective medical practice. Knowledge of traditional Chinese medicine has traveled in the United States in response to growing interest in alternative medical practices and as part of the cultural baggage of those who immigrate here. *Traditional* does not mean "unchanging," for practices in the home country are also influenced by history and developments in traditional medical practices abroad that find their way back (Zhan 2001).

The complex multidimensional and multidirectional changes experienced by immigrants, the receiving societies, and the societies "back home," with whom immigrants may maintain important contacts, are often reduced to a discussion about assimilation and acculturation, which are typically presented in simple, unidirectional terms. Often it is assumed that over time immigrants will shed as quickly as possible the cultural beliefs and behaviors they brought with them in exchange for "American" beliefs and behavior (Suárez-Orozco 2000). However, it is sometimes more appropriate, and healthier, for immigrants to retain some of their beliefs and behaviors. Ruben Rumbaut (1997a) has summarized the protective aspect of many beliefs and behaviors of immigrants, which has led to a number of paradoxes in the medical literature. High-risk Mexican and Asian immigrant women come to the United States with healthful behaviors, including eating a healthy diet and drinking and smoking less than US-born women. Although these women are poor and often deliver without adequate prenatal care, their children are, relatively speaking, born healthy, with low rates of low birth weight (Markides and Coreil 1986; Rumbaut and Weeks 1989; Rumbaut et al. 1988; Williams, Binkin, and Clingman 1986; Yu 1982). In time, however, their behaviors tend to become "American." They are more likely to take alcohol, smoke cigarettes, eat high-fat foods, and engage in risky sexual behavior. Consequently, less positive birth outcomes are correlated with assimilation. Similarly, Mexican immigrant women are less likely than Anglo women or African-American women

to get breast cancer. Perhaps related to diet, exercise, and increased income (Vernon et al. 1985; Vernon et al. 1992), their risk increases with more time in the United States. Japanese men in Japan smoke at twice the rate of American men but are diagnosed with lung cancer at half the rate. For Japanese men in the United States, this rate also increases with time. The reason is not totally understood but might be associated with dietary changes, including drinking less green tea, and the stress of living in a society with markedly greater income inequality than in Japan (Bezruchka 2001). As Rumbaut (1997a) has noted, assimilation can be bad for an immigrant's health.

The cultural beliefs immigrants bring with them are not the only things problematic from the perspective of receiving societies. A recurring problem has been the association of immigrants with disease, which socially stigmatizes them as a threat to the public's health. Recent examples include linking AIDS to Haitian immigrants, mental pathologies to Cuban immigrants, and malaria to Mexican immigrants, but this is not a new problem. In 1870s California, whites blamed Chinese immigrants for the spread of smallpox. In 1900, San Francisco's Chinatown was cordoned off by ropes and guarded by police in an attempt to quarantine the Chinese, who were believed to be the source of bubonic plague (Kraut 1994; Shah 2001). In 1906 New York, Mary Mallon, an Irish immigrant, acquired the nickname "Typhoid Mary," which became synonymous with the health threat associated with immigrants (Kraut 1994). In the first decade of the twentieth century, Italians were associated with outbreaks of typhoid in Philadelphia and polio in New York (Kraut 1994). The larger public often viewed these and other "less desirable" immigrants as threats to public health, a threat isomorphic with characteristics such as foreignness, lack of hygiene, and mental inferiority. The screening of immigrants for contagious diseases was a central component of the Ellis Island experience in the late 1800s. The 1924 immigration law mandated that the consulate in the immigrant's country of origin conduct a medical exam before the immigrant's departure for the United States (Kraut 1994).

The social stigma of carrying unwanted disease has left its mark on contemporary immigrants as well. In the early years of AIDS, little was known of its origin. Haitians, however, became associated with AIDS and were the only nationality to be listed as a risk factor for the disease,

raising questions about their suitability for immigration and their ability to donate blood (Farmer 1992). The Cuban refugees who came in the Mariel boat lift of 1980 were stigmatized by characterizations of criminal insanity and homosexuality, both of which were associated with threats to the public and its health (Borneman 1986). Mexican immigrants have been associated with rampant fertility, threatening the public health by overburdening its medical and welfare systems (Chavez 1997; Johnson 1995; Zavella 1997). Once acquired, the stigma of being a health menace can be difficult to shed. Such characterizations can mask actual health needs and the structural factors that cause ill health among immigrants, particularly poverty, crowded living conditions, dangerous occupations, lack of medical insurance, and the burdens associated with pariah status.

CULTURAL MODELS AND DISEASE

Less studied until recently has been the way immigrants' beliefs about biomedically recognized diseases differ from those of physicians and other biomedical practitioners. Between 1991 and 1993, I was co-principal investigator in a large study to examine Latinas' (both immigrant and US-born) beliefs and attitudes about breast and cervical cancer and their use of cancer screening tests (Chavez et al. 1995; Chavez, Hubbell, and Mishra 1999; Chavez et al. 1997). In the first year, we conducted ethnographic interviews with thirty-nine Mexican and twenty-eight Salvadoran immigrant women and compared their responses with those of twenty-seven US-born women of Mexican descent (Chicanas), twenty-seven Anglo women, and thirty physicians in northern Orange County, California (Chavez et al. 1995; Chavez, Hubbell, and Mishra 1999; Martinez, Chavez, and Hubbell 1997; McMullin, Chavez, and Hubbell 1996). These interviews were based on snowball and organization-based sampling. Interviews were conducted in the interviewees' language of preference and typically lasted from two to four hours. In year two of the study, we used these ethnographic interviews to help develop a telephone survey that was administered to a random sample of immigrant and US-born Latinas and Anglo women throughout the county (Chavez et al. 1997; Chavez et al. 2001).[3] The telephone survey totaled 803 Latinas, most of whom were born in Mexico (53 percent) or the United States (32.5 percent), with several

Latin American countries also represented, most notably El Salvador (3 percent) and Guatemala (2.7 percent). In year three, we developed and tested an intervention program targeting breast cancer beliefs and behaviors. Our findings suggested that the perceptions of Latina immigrants and physicians about cancer risk factors can be worlds apart, which has implications for doctor-patient communication, adherence to prescribed regimens, and the effectiveness of interventions to alter existing beliefs.

As part of the interview, we obtained from each informant a list of possible factors that might increase a woman's chances, or risk, of getting breast cancer. (See Chavez, Hubbell, and Mishra [1995] for a full discussion of the methods used.) We then selected the most salient factors listed for each group of women and arrived at twenty-nine risk factors. We asked each informant to rank the factors and to explain her ordering. Table 7.2 shows Mexican immigrant women's top-six ranked risk factors and the top six for physicians.

Mexican immigrant women's most important risk factors for breast cancer were hits or bruises to the breast; excessive fondling of the breast was sixth. The relative significance given to these two risk factors suggests the importance of physical stress and abuse as a cause of cancer in the women's cultural model. As one Mexican immigrant woman said: "Bruises to the breast are bad. The breasts are very delicate, so when a child sucks on the breast and leaves a bruise, it's bad. Hits to the breast can also cause cancer. And when the husband massages or squeezes the breast or sucks on it, that, too, can cause cancer" (quoted in Chavez et al. 1995).

For Mexican immigrants, lack of medical attention ranked second. As one Mexican immigrant woman indicated, this reflects a clear sense of the political economy of medicine: "I don't have insurance. In my opinion, if one doesn't have insurance, it's bad because, well, here cures are expensive, and, well, you know, sometimes for many people what we earn is not enough even to eat and live. So when we have these types of illnesses, we don't go to the doctor because of a lack of money" (quoted in Chavez et al. 1995).

They also emphasized cigarette smoking, birth control pills, and breast implants. These risk factors suggest that the lifestyle choices women make can possibly lead to breast cancer.

Table 7.2
The Six Highest-Ranked Breast Cancer Risk Factors for Mexican Immigrants and Physicians in Orange County, California

Risk Factors	*Mexican Immigrant Women's Ranking*	*Physicians' Ranking*
Hits/bruises to the breast	1	26
Lack of medical attention	2	11
Smoking cigarettes	3	10
Birth control pills	4	13
Breast implants	5	15
Excessive fondling of breasts	6	29
Heredity, family history	7	1
Getting older	25	2
Having first child after age 30	21	3
Never having a baby	23	4
Obesity	17	5
Hormone supplements	16	6

(Source: Chavez et al. 1995)

Physicians emphasized risk factors found in the epidemiological literature. As Table 7.2 indicates, physicians ranked heredity or a family history of breast cancer first and foremost, followed by getting older (aging), having a first child after age thirty, never having a baby (the preceding two relate to not having the periods of interrupted estrogen production that occur during pregnancy), obesity, and hormone supplements (continued exposure to estrogen).

As Table 7.2 suggests, the correlation between Latina immigrants' views of important risk factors for cancer and those of the physicians is an inverse one. The risk factors ranked as important by the immigrant Latinas were ranked as unimportant by the physicians, who claimed these to be superstition or off the radar of contemporary epidemiological research. The risk factors the physicians ranked as important were generally ranked as unimportant by immigrant Latinas because they were unfamiliar with such notions or did not see any relevance to breast

cancer. These and other findings contributed to the development of questions examined as part of the broader survey conducted in year two of our study.

These divergent models of breast-cancer risk factors suggest the difficulty immigrants may encounter when attempting to communicate with physicians. Immigrants and physicians may not understand much about each other's views. Turner (1987) has suggested the existence of a "competence gap" in biomedical knowledge that impedes effective communication between physicians and their patients. This gap can go both ways. Physicians may not be aware of the beliefs informing immigrants' views of disease and risks. Immigrant Mexican and Salvadoran women might have viewed certain risk factors as unimportant because of a lack of basic biomedical knowledge. Also, immigrant women have definite beliefs about behaviors that, in their view, constitute possible risk factors for breast cancer. These beliefs may derive from a multitude of sources: knowledge transmitted among family and friends, popular media, conversations with health practitioners, and cultural beliefs that are much broader than cancer itself. Indeed, Latina immigrants often located their discussion of cancer in the moral, gender, and material contexts of their lives (Martinez, Chavez, and Hubbell 1997).

SOCIAL AND ECONOMIC FACTORS INFLUENCING ACCESS TO MEDICAL CARE

In the United States, immigrants confront a medical system under assault from many directions, which can make obtaining medical care a major challenge. Frequently, this access is relative to the resources immigrants manage to acquire through their participation in the US labor market. We wanted to investigate this in the study of Latina beliefs and attitudes about cancer. Sociodemographic data collected in year two of that study suggest some of the immigrant women's basic medical needs, shown in Table 7.3.

Latino immigrants in Orange County have, on average, demographic characteristics that set them apart from the US-born population, and these characteristics have important implications for their medical needs. As mean ages in Table 7.3 suggest, Latina immigrants are significantly younger than whites. This trend toward an aging population, especially among non-Latino whites, is expected to continue,

TABLE 7.3

Sociodemographic Characteristics of Latina Immigrants, Latina Citizens, and White Women in Orange County, A Random Sample Telephone Survey, 1992–1993

	Latina Undocumented Immigrants N = 160	Latina Legal Immigrants N = 311	Latina Citizens N = 313	White Women N = 422
Demographic Characteristics				
Median age	27	33	34	41
% Children <18 living with respondent	81	82	62	49
Median years of schooling	9	9	13	14
Median language and acculturation score (5-point scale)	1.0	1.2	4.2	NA
Current Work Status				
% Employed full-time	24	42	53	51
% Employed part-time	14	10	12	12
% Homemaker	44	31	17	18
% Unemployed, seeking work	10	6	5	3
% Unemployed, not seeking work	9	10	9	6
% Retired	0	1	4	11
Spouse's Work Status				
% Employed full-time	67	80	79	80
% Employed part-time	15	6	2	2
% Unemployed, seeking work	16	7	6	3
% Unemployed, not seeking work	3	4	4	2
% Retired	0	2	10	13
Household Income				
% <$15,000	76	46	14	10
% $15,000–$24,999	17	31	23	12
% $25,000–$34,999	4	8	12	10
% $35,000+	1	15	51	68
Medical Insurance				
% Private insurance	21	52	77	85
% Government insurance, Medicare, Medi-Cal, IMS, etc.	18	13	13	14
% Medically uninsured	61	35	10	1
% No regular source of medical care	41	16	4	2

(Percentages may not add up to 100 because of rounding. Source: Chavez et al. 1997.)

with people sixty-five and older expected to increase to 37 percent of the population by 2050 (US Bureau of the Census 1996). The United States will find ever greater proportions of its medical expenditures going toward geriatric care and illnesses related to aging.

However, the majority of immigrants are concentrated in the younger, working-age bracket, especially in the fifteen to thirty-four age group. Few immigrants are sixty-five and older. Latinas are generally younger than Anglo women. In the study, Anglo women were, on average, in their early forties, approaching the end of their reproductive years. Latinas were in their early thirties, but their age varied with immigration status, most undocumented Latinas being in their late twenties. Latinas were in their reproductive years. An indication of this is the proportion of Latinas who had children under age eighteen living with them. As Table 7.3 indicates, more than 80 percent of Latina immigrants and 62 percent of Latina citizens were living with their minor children, compared with only about half the Anglo women. Although this proportion is high for Latina immigrants, it would have undoubtedly been higher if we had included the Latina immigrants who left their young children in their place of origin.

The age structure of immigrants indicates that medical needs center around maternal and child health care for women and work-related problems for both men and women. These demographic trends also suggest an area of possible future conflict in the politics of medical care: To what degree will maternal and child health care—increasingly associated with immigrants—become less of a priority in a society beleaguered by the needs of its aging native population?

Access to medical services in America, especially for non-emergency medical care, depends on the patient's ability to pay. Lacking a government-sponsored, national health-care system, which would guarantee services for all US residents, patients must prove their ability to cover expenses. Patients can cover medical costs out of pocket, with a direct cash payment for services rendered, an exchange more suited to care from a private physician than a clinic or hospital, where medical costs can quickly become exorbitant. Often required for medical services, especially from hospitals, is proof of third-party payment guarantees, which translate as private or government-sponsored insurance programs. Immigrants are usually at a disadvantage when attempting to

meet these financial tests, primarily as a result of the nature of their integration into the labor market. However, not all immigrants are equally disadvantaged. Undocumented immigrants are less likely than legal immigrants and Latina citizens (mostly US-born) to acquire the financial wherewithal and insurance coverage necessary to open the door to medical care. Again, let me turn to data I have collected in Orange County, California, to illustrate these points. Orange County is a particularly good place to examine issues of immigrants' access to medical services because it is one of the wealthiest counties in the nation and boasts good access to health services (Warren 1999).

Latina immigrants in Orange County bring with them a range of human capital assets. These influence their participation in the labor market, which, in turn, affects their acquisition of the resources (income and medical insurance) needed for medical services. Two important factors are education and familiarity with the English language. As Table 7.3 indicates, Latina immigrants (both undocumented and legal) had a median of nine years of education. In contrast, Latina citizens and Anglo women had a median of one year and two years of college, respectively. In addition, Latina immigrants scored low on a standard language/acculturation index composed of five questions primarily related to language use. An undocumented immigration status is also a factor limiting labor market participation, especially mobility.

The information on the work status of women interviewees and their husbands provides insight into the disadvantaged position of undocumented immigrants in particular. (Data were collected during a period of recession in southern California.) With about one-quarter of undocumented Latinas working full-time, they were the most likely of all the women we surveyed not to work outside the household. On the other hand, they were more likely to work part-time. Most of their spouses worked full-time but not in the same proportion as the other groups. Their spouses were also much more likely to work part-time than the spouses of the other women. In fact, they were seven times as likely to work part-time as the spouses of Anglo women and Latina citizens and two-and-a-half times as likely as the spouses of legal immigrants. Both undocumented Latinas and their spouses were also more likely to be unemployed and seeking work than all others. These data suggest that a lack of legal immigration status places immigrants in a

disadvantaged position in the labor market. Finding steady, full-time employment can be difficult for them, at least in comparison with legal immigrants and US citizens. Also note that, compared with Anglos, few Latina immigrants surveyed were retired, reflecting the disparity in average ages.

Income data for the families of the women we surveyed showed an inverse correlation with changes in citizenship status. Most (76 percent) of undocumented Latinas clustered in the under $15,000 per year category. Legal Latina immigrants managed to move into higher income categories, but most (77 percent) had annual household incomes under $25,000. In contrast, citizen Latinas were found much more often in the higher income categories, and Anglos predominately in the highest income category. All Latina immigrants have generally low incomes, which, when combined with the likelihood of their having children living with them, suggests that they would encounter difficulties covering out-of-pocket the cost of their family's medical care needs.

Undocumented Latina immigrants were also the most likely to lack medical insurance. As Table 7.3 indicates, few undocumented immigrants had private medical insurance, which is typically a benefit of employment. Some did have government-sponsored insurance, usually prenatal care or Medi-Cal for their US-born children. Overall, though, 61 percent of undocumented Latinas were uninsured, lacking one of the main keys that open the door to non-emergency medical care. Legal immigrants fared better, but more than a third lacked medical insurance. Interestingly, one out of ten citizen Latinas did not have medical insurance, whereas almost all Anglos had access to some form of medical insurance. Not surprisingly, many undocumented immigrants did not have a regular source of medical care. Latina legal immigrants were more likely to have a regular source of medical care, and almost all citizen Latinas and Anglos had a regular source of medical care. A regular source of medical care is highly correlated with health status, and lacking such a relationship indicates a problem area in medical service.

ACCESS TO MEDICAL CARE—A TWO-TIERED SYSTEM?

The study of Latinas and cancer sheds light on additional aspects of access to care that are, no doubt, relevant to other groups as well. If

we examine the types of services used by those women in the study who did not have a regular source of medical care, a pattern emerges that correlates with the resources (income and medical insurance) available to immigrants and citizens. As Table 7.4 indicates, undocumented Latinas rely first on public health clinics and then on hospital outpatient clinics, followed by private physicians who can be paid in cash "with no questions asked." For a few undocumented Latinas, hospital emergency rooms are the primary source of care, and this is a costly alternative. Latina legal immigrants turn to private physicians most often, but not to the same degree as Latina citizens and Anglos. Latina legal immigrants also rely on public health clinics and hospital outpatient clinics, with some belonging to health maintenance organizations (HMOs). For Latina citizens and Anglos, private physicians and HMOs are the most important sources of regular medical care. To a certain extent, these patterns suggest that a two-tiered system of medical care exists: one for the medically insured and one for the uninsured, for whom access to medical care is a constant problem (National Health Foundation 1995).

For Latina immigrants without a regular source of medical care, the use of medical services also depends largely on their medical insurance coverage. The uninsured with no regular source of medical care often search out a private physician who will take cash up front for minor health problems. For some, the barriers, including cost and even a general lack of knowledge about how to access medical services, can prove to be too formidable. On March 28, 1989, five-year-old Sandra Navarrette died in Orange County of chicken pox, a childhood disease that is rarely fatal in the area. Her parents were undocumented immigrants from Mexico who did not take her to a hospital until it was too late to save her. They had been in the United States only a short time and did not know where to find medical services (Chavez, Flores, and Lopez-Garza 1992). Unfortunately, for many immigrants who lack medical insurance and experience episodic illnesses or injuries, there may be no alternative to the hospital emergency room as the primary source of medical services. However, emergency room costs can quickly outstrip immigrants' meager resources, and hospitals are then left with unpaid bills (Clark et al. 1994).

Not surprisingly, the politics surrounding the provision of medical

TABLE 7.4
Sources of Medical Care for Immigrant Latinas, Latina Citizens, and White Women in Orange County Who Had a Regular Source of Care, A Random Sample Telephone Survey, 1992–1993

	Latina Undocumented Immigrants N = 160	Latina Legal Immigrants N = 311	Latina Citizens N = 313	White Women N = 422
Private physician	21%	44%	66%	77%
HMO	1%	6%	16%	16%
Hospital outpatient clinic	25%	17%	8%	3%
Public/community clinic or health center	45%	30%	9%	3%
Hospital emergency room	4%	0.4%	0%	0.5%
Other	3%	1%	3%	0.2%

(Percentages may not add up ot 100 because of rounding. Source: Chavez et al. 1997.)

services, including the delivery of babies, stimulate some of the most contentious public-policy debates (Berk et al. 2000; Johnson 1996; Johnson 1995; Mills 1994; Rumbaut et al. 1988; Zavella 1997). For example, former governor of California Pete Wilson made cutting off undocumented women from prenatal care one of his central political concerns (Lesher and McDonnell 1996). California's Proposition 187 in 1994 sought to deny undocumented immigrants access to medical and other social services and to compel physicians and other medical personnel to turn in undocumented immigrants seeking medical services to the Immigration and Naturalization Service (Chavez 1997; Martin 1995). Although most of Proposition 187's provisions were never implemented, because of constitutionality issues, it provides a compelling example of the extent to which medical care, and other social services, for immigrants can become embroiled in public controversy and even nativist sentiment (Calavita 1996; McDonnell 1997).

Proposition 187 was ultimately a symbolic statement about the public's unease with increasing immigration, but the 1996 welfare reform law actually denied immigrants, both legal and undocumented, access to many medical and social services (Shogren 1996). Medicaid

use illustrates the impact of this reform on immigrants. Between 1994 and 1997, non-citizens' use of Medicaid, an important government program for support of medical needs, dropped precipitously, from 39.8 percent to 32 percent, a 19.6 percent reduction in the proportion of non-citizens using the program.The Medicaid enrollment for citizens stayed steady before and after welfare reform (30.3 percent to 30 percent) (Fix and Passel 1999). This decline occurred among non-citizens who were below 200 percent of the poverty level, which is generally considered the low-income category. Although closing the door on medical and other social services for immigrants may reduce costs for government programs in the short run, having medically under-served people among us is not a wise policy in the long run. Untreated medical problems become more costly with time. Contagious diseases are best cured quickly—illness does not distinguish between citizens and non-citizens. Facing obstacles to conventional treatment, immigrants often resort to home treatment or alternative curers and dispensers of remedies. From the government's perspective, these alternative health-care providers are problematic because they are unregulated by conventional codes of practice and safeguards.

Unregulated health-care providers emerged as a problem area for regulation after several well-publicized cases of unlicensed persons dispensing medicine and possibly dangerous remedies to patients. For example, a common affliction in Mexico and among Mexican immigrants in the United States is *empacho,* described as a blockage of the intestines caused by food becoming stuck. One remedy sold in Mexico and imported to the United States contains high levels of lead powder, which is especially dangerous for children. In addition, "fake" doctors (practicing medicine without licenses) operate out of clinics in immigrant neighborhoods. Their work comes to light when a tragedy occurs, as happened in April 1998 in Santa Ana, California. A thirteen-month-old child died after receiving treatment from a man who had been practicing medicine at a clinic for nearly a year without a license (Reza 1999). Lay people sometimes dispense drugs or injections of medicine at low cost to customers out of the back rooms of neighborhood grocery stores, bodegas, video stores, and other shops (Guccone and Blankstein 2002; Haynes 1997; Terry 1997). Such activities also come to light after tragedy strikes. For example, in Tustin, California,

on February 22, 1999, a toddler died after receiving an injection of penicillin administered in the back room of a gift shop (Reza 1999). Although the child was found to have died from dehydration and not the injected medicine, such cases suggest the health risks posed by the use of clandestine medical treatments and highlight the difficulty of finding adequate medical services from conventional providers (Guccone and Blankstein 2002; Weber 1999; Yi and Jack 1999). However, we still do not understand all the factors related to the use of alternative health-care providers (Chavez and Torres 1994).

My own research and that of others suggest that immigrants turn to alternative sources of health care for many reasons. Such providers include spiritual healers who are effective when illness is believed to be related to spirits or when intervention with the spirit world is required (Fadiman 1997; Holliday 2001). Some illnesses may also require traditional herbal medicines and other paraphernalia found in shops (*botanicas* in Spanish) (Holliday 2001). Many folk illnesses require the services of a culturally appropriate healer who can provide the necessary treatment or herbal remedies. In such cases, immigrants' use of healers may reflect a preference based on cultural similarities and appropriateness (Chavez and Torres 1994). This may be particularly true in the case of spiritual healers, with whom patients share religious beliefs (Chavez 1984; Rubel, O'Nell, and Ardon 1984). Other times, immigrants turn to clandestine practitioners or spiritual healers for medically related practices that the larger society looks upon with disdain or stigmatizes, such as female circumcision and animal sacrifice. When this occurs, it can spur societywide debates, even legal cases, over the limits to society's obligation to tolerate questionable cultural practices (see Shweder, Chapter 9).

For Mexican immigrants, medical care in Mexico, which is not that far away, is an appealing alternative. Reasons for crossing the border include cultural factors, such as familiarity, ability to communicate in a common language, and the convenient availability of drugs over the counter without a prescription. In addition, Mexican immigrants find that health practitioners in Mexico "understand" their health problems, sometimes in contrast to a "bad" experience in a US medical encounter (Chavez 1984). Not surprisingly, the Mexican immigrant women (28 percent) participating in ethnographic interviews for our

cancer study were more likely than Chicanas (7 percent), Salvadoran immigrant women (4 percent), and Anglo women (4 percent) to have sought care in Mexico for health problems. This proportion is almost identical to that in a study I was involved with in the early 1980s, in which 31 percent of Mexican immigrants (N = 2,013) in San Diego County had gone to Mexico for medical care at least once since coming to the United States (Chavez 1984).

The frequency of immigrants' use of alternative curers is difficult to determine fully. In our cancer study, we asked informants in ethnographic interviews and respondents in the broader survey about their use of alternative curers. Of the 533 immigrant Latinas surveyed, 3.8 percent had been to a folk healer *(curandero),* herbalist *(yerbero),* or spiritualist *(espiritualista).* This was the same proportion as US-born Latinas (also 3.8 percent, N = 260). Interestingly, Anglo women (7.1 percent, N = 422) were more likely than Latinas to have sought care from alternative healers. More interviewees thought that one or more of these alternative healers could cure certain types of cancer: 12.8 percent of Latina immigrants, 15.5 percent of US-born Latinas, and 21.9 percent of Anglo women. As these findings suggest, not only immigrants seek alternative answers to questions about health and spiritual well-being. Anglos and other natives turn to spiritual healers and seek the curing power of crystals, prayers, and other non-biomedical alternatives (Baer 2001; McGuire 1988).

Ethnographic interviews in our study with Latina immigrants suggest that folk healers are good for certain ailments, especially stomach problems and folk illnesses such as *empacho, mollera caída, bilis,* and *susto.* Many Mexicans (26 percent), Salvadorans (29 percent), and Chicanas (15 percent) said that they would go to a *curandero* if a problem required it. Ethnographic interviews also suggest that Mexican and Salvadoran immigrants place much stock in the efficacy of herbal remedies, with almost half the Mexicans (49 percent), Salvadorans (46 percent), and Chicanas (48 percent) indicating that they would seek care from an herbal specialist. Herbal remedies, especially teas or salves, were suggested for a plethora of health problems, including stomach problems, bile problems, nerves, diabetes, colic, diarrhea, skin rashes, congestion, headaches, menstrual cramps, sore throat, kidney problems, and many more. Importantly, seeking care from a doctor did

not preclude trying herbal remedies, and vice-versa.

Although some informants said that they went to an herbal specialist or to Mexico, where good herbal remedies are sold in stores and by street venders, many more indicated that herbal and other remedies are part of everyday knowledge and could be found around the house, bought at a pharmacy, or borrowed from a neighbor. They used teas, especially mint tea *(yerba buena),* and common remedies such as aspirin, Tylenol, wood alcohol, Vicks VapoRub, and cold medicines. Informants indicated that they would typically try to cure, at home or with the help of a relative or friend, mostly "minor problems" such as colds, sore throats, flu, headaches, stomach aches, fevers, small cuts, abrasions, and sore muscles. As a twenty-seven-year-old Mexican immigrant said, "Sometimes I try to treat [problems] that are not serious [at home]. Let's say someone has a fever. You might try and cure that using Tylenol, or alcohol. That's what we Hispanics use. It's part of our culture. It comes from our parents, who inculcated us, taught us that sometimes a bath and rubdown with alcohol reduces the [body's] temperature. That's why we don't go to a doctor, but try and cure a fever with Tylenol and an alcohol rubdown, and that's it."

Importantly, immigrants' social networks serve as a safety net that provides many social and cultural resources, including health remedies, and reinforces ties and solidarity among local neighbors and family (Menjivar 2002). Among our ethnographic interviewees in the cancer study, 18 percent of the Mexican and 21 percent of the Salvadoran immigrants had turned to a friend when they needed medical advice. For example, a sixty-seven-year-old Mexican immigrant woman said, "We have a very close friend who has almost forty years working in the university hospital. And he helps not just us, but everyone who asks him for advice he is ready to help. He advises us because he knows a lot about medicine because he works in an operating room, and he comes and he sees us and gives us advice. For example, my son last Sunday had a bad pain in his stomach, and we called him [the friend], and he told us that it was his appendix and that we should take him immediately to the doctor."

Cecilia Menjivar (2002) has noted that among Guatemalan immigrants in Los Angeles, health remedies are also part of the resources transmitted by transnational networks. Our ethnographic interviews

with Mexican and Salvadoran immigrants support Menjivar's observation. A Mexican immigrant said that, after noting the importance of vitamins for her gastritis, colon, stomach, and bile, she also took something for her liver, which she said "is prepared," noting, "They send it to me from Guadalajara [Mexico]." A twenty-eight-year-old Salvadoran immigrant said, "The majority of remedies I have brought to me from El Salvador. There are many herbs that can be used to cure, for example, for body pains. There are many herbs there that I know how to use, that are sent to me from El Salvador."

In sum, immigrants, such as those from Mexico and other parts of Latin America, often find medical services difficult to access. They face a host of social, economic, and cultural barriers. However, immigrants are resourceful, often turning to the medical knowledge of family and friends and sometimes of alternative medical practitioners to meet their health-care needs.

INTERVENTIONS

Up to this point, we have examined the interwoven cultural and structural factors that complicate immigrants' use of medical services. Many anthropologists working with immigrants also attempt to "do something" with their research, to apply what they have learned to policy issues or toward improving conditions for the people with whom they have conducted research (Farmer 1999). There are many ways to accomplish this task. One is to work toward changing public policies and laws that restrict immigrants' use of medical services. Anthropological findings can inform legislation and be brought to bear in lawsuits. Anthropologists sometimes work directly with immigrants in non-governmental agencies, providing services and knowledge to assist individuals in the acquisition of care. Another approach is through the development of intervention programs that test a theory of how best to introduce changes.

Medical interventions often seek to change existing beliefs and behaviors, typically focusing on the patient. I have helped develop and implement an intervention with the goal of introducing biomedical beliefs about breast-cancer risks in a culturally appropriate and sensitive manner. Although I believe that we were successful, my experiences also made clear to me both the strengths and weaknesses of such

interventions, particularly the focus on individuals instead of the broader, societal factors influencing immigrants' use of medical services. After a brief overview of the intervention, I will discuss critical problems with this approach.

Using the knowledge we gained from ethnographic interviews with Mexican and Salvadoran immigrant women, we developed an intervention aimed at introducing biomedical ideas about risk factors for breast cancer and increasing their practice of breast self-examination and routine mammography (Chavez, Hubbell, and Mishra 1999; Mishra et al. 1998). The intervention took into account the population's relatively low levels of formal education, low income, and preference for the Spanish language. Moreover, we felt that it was imperative to incorporate the Latinas' beliefs into the intervention rather than dismiss them as silly or folkloric. In addition, we were sensitive to the concept that the separation of health problems from a target population's belief systems and daily routines may diminish the effectiveness of health education efforts (Bandura 1982). Finally, we wanted to design an intervention that would have the best chance to change not only knowledge and attitudes but also behavior.

With these considerations in mind, we modeled the intervention on Bandura's theory of behavioral change (Bandura 1977, 1982) and on Freire's empowerment pedagogy (Freire 1970, 1971). In brief, Bandura's theory predicts that individuals will change their self-efficacy (beliefs about their own power, their own abilities) after they have mastered a task and experienced its effectiveness. An increased sense of self-efficacy leads to changes in behavior that may produce improved outcomes. For example, a woman is more likely to perform breast self-examination if she feels competent to do it. If a clinician validates a woman's findings, she will feel more competent in routine self-examination. The intervention also employs lessons learned by Paulo Freire during his literacy campaigns in developing countries, based on Bandura's theoretical perspective. Latinas in our study share many cultural and socioeconomic attributes, such as low levels of formal education, with groups that have already been helped by his empowering pedagogy. Freire found that individuals with low educational attainment absorb new information best when it is presented in a way that relates to their current environment and life circumstances. Therefore, the

educational process should allow students to introduce into the educational setting any issues that relate to their broader social context and affect their beliefs about the health problem (in this case, breast cancer). The educator then empowers the students to make breast cancer control their own problem instead of the educator's. Through this strategy, the educator and the participants become involved in an interactive process that leads to more information sharing about breast cancer-related beliefs and enables the women to become actively involved in a problem-solving process that may result in their improved health.

The theoretical model for the intervention stressed the need for the learner to "own the problem." Freire developed what he termed a "problem-posing" educational method. He contrasted the problem-posing method with the banking concept of education, wherein "knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing" (Freire 1970). He explains that the banking concept reinforces the individuals' fatalistic perception of their situation and, consequently, does not allow students to shape their own actions to achieve needed change. By contrast, the problem-posing method presents a particular situation to students as a problem to be solved by the group. This model of learning encourages the individual to analyze the way she perceives reality. Within this framework, the educational process involves "give and take" communication. In an open dialog with the educator, students can internalize and evaluate critically the information they receive. Given such an educational environment, students become intimately involved in the subject, and the solutions that are developed will likely be applicable to their own lives.

We pilot-tested an empowerment-model intervention in a university-affiliated community clinic in Orange County. During each session, a health educator posed questions designed to encourage thought and discussion about the potential impact of breast cancer on the lives of the participants, about risk factors and symptoms of breast cancer, and about prevention and treatment of the disease. The educator then guided the group to come up with solutions to the problem of breast-cancer control. We obtained measures of breast cancer–related knowledge, attitudes, and practices before, immediately following, and six weeks after the intervention in the experimental group and in a con-

trol group that did not receive the intervention. Results of this pilot test enabled us to determine the effectiveness of the empowerment methodology in improving breast-cancer control among Latinas.

The results of our pilot test have been published elsewhere (Chavez, Hubbell, and Mishra 1999; Mishra et al. 1998). Suffice it to say that we were successful in our efforts to introduce new ideas and methods to detect breast lumps without denigrating pre-existing beliefs. However, a major strength of our approach was also a major limitation. The intervention we developed works well with small groups. It relies on individuals to transmit their new understandings to relatives and friends in a snowball effect. This is a very time-consuming method. Although it may have effectively changed beliefs and behaviors of individuals, it did nothing to alter the structural obstacles encountered by Mexican immigrant women, and other low-income people, when seeking medical services. We were faced with a very real dilemma. We could increase awareness of the positive value of preventive care and use of cancer-screening exams and, thus, the desire to obtain such care. However, we could do nothing about the cost of medical care, financial screening, lack of medical insurance, English language skills, and immigration status, to name a few of the structural barriers for Mexican immigrant women.

We did "a little good" but realized, with frustration, that only fundamental changes in embedded societal inequalities would have a real and lasting impact on immigrants' lives and well-being (Farmer 1999). Ultimately, many of the greatest threats to immigrant health and their use of medical services lie outside their own beliefs and behaviors. These are related to the growing gulf between the haves and have-nots in American society. Stephen Bezruchka (2001), an M.D. who teaches at the University of Washington's School of Public Health, summed up the problem well: "Research during the last decade has shown that the health of a group of people is not affected substantially by individual behaviors such as smoking, diet and exercise, by genetics or by the use of health care. In countries where basic goods are readily available, people's life span depends on the hierarchical structure of their society, that is, the size of the gap between rich and poor."

Medical interventions focusing on the individual may make positive, important incremental changes in individual lives. However,

immigrants (and many poor citizens) would benefit hugely from higher wages, mandatory medical insurance provided by employers, a national health-care system, increased funding of ESL (English as a Second Language) classes, more enforcement of fair labor standards and practices, and even a greater public recognition that immigrants are not a drain on social services but are contributing members of society.

MEDICAL ANTHROPOLOGY AND IMMIGRATION—A MUTUAL BENEFIT

Finally, medical anthropology and immigration research are not mutually exclusive interests. They are mutually beneficial. My own research has been an example of this point. An attention to medically related issues and problems has helped me better understand the immigrant experience. The first study I conducted on immigration had, as a special component, the use of medical services (Chavez 1984; Chavez, Cornelius, and Jones 1985). At the time, public discourse characterized immigrants, especially Mexicans, as over-utilizing medical resources and becoming a burden on society. Our study sought to introduce empirical research into the debate. Even though the impetus for our research was to fill what we perceived was a gap in knowledge, it quickly became clear that health beliefs and health care were important in the lives of the people we interviewed. Their experiences, fears, and frustrations applied to them not just as immigrants but also as human beings suffering illness, injuries, and stresses in their lives. The formidable obstacles they faced in trying to alleviate these problems were not theirs alone but were extreme examples of obstacles also encountered by low-income and marginalized citizens.

It is here that immigration studies and medical anthropology are so mutually beneficial; ultimately, both are about understanding the human experience. Because our research seeks to be holistic in its approach and perspective, it is wise to remember that health and use of medical services are not separate from working conditions, living conditions, the politics of belonging to society, and the allocation of resources and benefits. We cannot fully understand the range of meanings and limitations of concepts such as citizenship, community, and social integration without attending to the health and well-being of immigrants.

Notes

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1. Kleinman suggests eight questions: What do you call the problem? What do you think has caused the problem? Why do you think it started when it did? What do you think the sickness does? How severe is the sickness? What kind of treatment do you think the patient should receive? What are the chief problems the sickness caused? What do you fear most about the sickness?

2. See Dressler (1996, 1999) and Janes (1990) for a discussion on the impact of stress on migrants' well-being. See also Cervantes, Salgado de Snyder, and Padilla (1989) for the incidence of post–traumatic stress disorder among refugees and labor migrants from Mexico and Central America.

3. Trained bilingual women interviewers from the Field Research Corporation in San Francisco conducted the telephone survey from September 1992 to March 1993.