

People, Not Problems: An Intervention Against Dehumanization in Health Care

by Bliss Baird

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By the time my fellow volunteers and I arrive at the church-turned-clinic, the line that forms early every Saturday morning has already been ushered inside. The patients have checked in, selected a seat in the hall or fellowship room, and helped themselves to a cup of coffee. English, Spanish, and Vietnamese phrases swirl as we parade through a corridor of resigned expressions. These patients know to expect a lot of waiting. In fact, the regulars are so sure of what to expect on Saturday mornings that they seem to guide the volunteers through the triage routine rather than the other way around! Though exceptional by any standard, their familiarity with medical proceedings and comfort in a medical setting is especially remarkable given that many people in their position feel out of place in healthcare facilities – awkward enough that they would face agony rather than seek care. These are no ordinary patients, and this is no ordinary clinic. For the many who are undocumented, this converted church is the only welcoming “medical” facility. Layers of barriers – financial limitations, language differences, legal constraints, discrimination, and negative past experiences in healthcare facilities – often impede successful medical treatment and alienate undocumented

immigrants from the care they need as desperately any other person. The exclusionary structure of the American medical system is a blatant violation of undocumented immigrants’ human rights, and, left unaddressed or under-addressed, the chasm will continue to undermine medical professionals’ noble aspiration to heal humanity.

In support of a pro-immigrant initiative within the medical field, I first present undocumented immigrants’ current lack of healthcare access, delineating how their alienation is problematic economically, constitutionally, and morally. I then illuminate less obvious but equally damaging interpersonal obstacles that confront undocumented immigrants who do gain access to healthcare. Lastly, I conceptualize an agenda for the medical establishment to promote the wellbeing of all its patients.

Undocumented immigrants receive significantly less medical attention than other portions of the population. In California, a highly diverse state, only two-thirds of undocumented Mexican immigrants report having a primary care facility, compared to 79% of immigrants wielding green cards, 88% of American-born Mexican-Americans, and 92% of US-born



Immigrants undergoing health screenings in the late 19th Century. The Immigration Law of 1891 made such screenings mandatory for all immigrants who wished to enter the United States.

American citizens (Wallace 509). According to a 2006 study by the RAND Corporation, less than 60% of undocumented immigrants had visited a doctor in the past year, and nearly 90% managed to avoid hospitalization (Goldman 1705). The health expenditures of an undocumented man were 39% of those incurred by a US-born male, and undocumented women spent barely more than half of native-born women (Goldman 1706–07). Consistent with these per capita statistics, the 3.2% of the American population that is undocumented is estimated to contribute only 1.5% to the national total health cost (Goldman 1709). In healthcare spending, undocumented immigrants represent two for the price of one.

Why is this spending a problem?

In one way—and one way alone—it is not. Youth and healthfulness reduce spending. In the RAND study, twice as many native-born as undocumented respondents reported a chronic condition (Goldman 1705). Rather than good fortune, this trend is credited to a “strong positive migration selection on health” (Ibid.): the demanding border crossing and likely employment doing strenuous labor make migration unappealing, if not impossible, for the feeble. In fact, the term “the Hispanic paradox” has been coined to describe first-generation Hispanic immigrants’ surprising record of health given their often suboptimal living and working conditions (Garg 27).

If their absence from hospitals could be attributed solely to fitness, undocumented immigrants should be envied rather than aided. However, when their health falters—and it will—numerous barriers impede undocumented immigrants’ pursuit of medical services. The most noticeable hardship is that undocumented immigrants are not eligible for publicly funded insurance such as Medicaid and the tax credits created by the Affordable Care Act (Sommers 594). Even beneficiaries of the DREAM Act, individuals brought to the US as children who can attain legal status through military service or

higher education (Miranda 2), are excluded (Sommers 594). Nearly two-thirds of undocumented immigrants are uninsured, about four times the rate of the population as a whole (Sommers 593–94). Insofar as insurance determines access to medical services, undocumented immigrants’ low healthcare participation is an offshoot of unfavorable public policies (Wallace 509).

The ever-frugal taxpayer may find undocumented immigrants’ minimal usage of healthcare agreeable. After all, few would desire to pay a cent more than the eleven dollars a year they currently spend on undocumented immigrants’ medical needs (Goldman 1710). But minimal primary care is not without its costs. While uninsured immigrant children receive 86% less medical treatment than their US-born counterparts, they visit the emergency room three times as frequently (Okie 526). Such trips to the ER are a menace not only to the individual who suffers a medical complication and the family who deals with added stress but also to American finances. Megha Garg explains that “taxpayers already pay for the care of undocumented immigrants” (27). Since the Emergency Medical Treatment and Active Labor Act of 1985 requires hospitals to treat all emergency patients, the only place where undocumented immigrants are guaranteed medical attention is the emergency department, but administering simple services like dialysis is much less cost-efficient in the ER (Garg 26–27). According to Garg, the current approach also fails to capitalize on an enormous opportunity. Citing the Hispanic paradox, she reasons that millions of vigorous, young undocumented immigrants could shoulder an insurance system that depends on ample healthy participants (27). The fiscal benefits of allowing immigrants to access more cost-efficient treatments and to support the system should reconcile parsimonious taxpayers to the concept of insuring undocumented immigrants.

While financial considerations necessitate healthcare reform, moral arguments are even more pressing. Americans should be disturbed by the precedent that is being set: policies are making healthcare inaccessible to citizens! Undocumented immigrants' wariness of the medical system infects their relatives. Discriminatory policies have a "chilling effect" in which millions of citizens, especially children, are deterred from exercising their right to social welfare services out of fear that their family members may be discovered and deported (Sommers 594). By discouraging citizens from claiming their rights, the government fails to satisfy its social contract.

Constitutional scholar Owen Fiss illuminates another inconsistency between the social contract outlined in the Constitution and current healthcare policies. In his protest to the 1996 Welfare Reform Act that barred immigrants from welfare benefits and Medicaid, Fiss argues from the Thirteenth and Fourteenth Amendments and *Plyler v. Doe* that "the constitutional guarantee of equality bars not just discrimination, but also laws that create or perpetuate caste-like social structures" (3). The Constitution, he asserts, "is a statement about how a society wishes to organize itself," and since American society has chosen egalitarianism (at least in principle), "no one, innocent or not, should be transformed by the state into a pariah" (Fiss 5). As Fiss warned, the 1996 Welfare Reform Act has indeed subjugated a portion of the American population. After evaluating undocumented immigrants' inferior access to healthcare, Dr. Benjamin D. Sommers concludes that "a medical underclass comprising more than 10 million people" exists in the nation renowned for equality (595). This hypocrisy is as dangerous as it is disgraceful: a shift away from any Constitutional right erodes the stability of all others.

Ultimately, the reason to ensure that undocumented immigrants have access to adequate healthcare is humanitarian. In an

attempt to codify human rights around the world, the United States supported and ratified the United Nations Universal Declaration of Human Rights. However, America's treatment of undocumented immigrants raises the question of whether our legislators have even read Article 25: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control" (7). Even supposing that an undocumented immigrant's presence in America is not "beyond his control," his health—just like my health, just like your health, just like the staunchest nativist's health—is often precisely that. To argue otherwise necessitates blaming a child for his asthma, a young mother for her cancer, an old man for his Alzheimer's. Unless we want to regress to viewing all illness as punishment, we must recognize that needing medical care is not a crime. Rather, it is a necessary and potentially unifying aspect of human existence. The math is simple: because undocumented immigrants are 100% human, giving them 50% as much healthcare cheats them out of half the help they deserve.

As Garg is quick to note, legislation granting public health insurance to undocumented immigrants is unlikely in today's political environment (25). But even if insurance reform seemed probable, myriad other barriers would remain. In fact, the unlikelihood of positive political changes may be beneficial in that it concentrates attention on other aspects of the vicious cycle that plagues undocumented healthcare-seekers, such as negative past experiences in healthcare facilities. Even a doctor, Susan Okie, acknowledges that "for recent immigrants—especially the estimated 12 million who are here illegally—seeking health care often involves daunting encounters with a fragmented,

bewildering, and hostile system" (525). A 2012 study makes that discomfort painfully obvious. Endeavoring to "understand the world of the participants from their perspectives," Juliet Chandler, Ruth Malone, Lisa Thompson, and Roberta Rehm followed 26 undocumented, uninsured, and chronically ill Mexican immigrant women who attended a free clinic in California (24-25). In their interviews, one phrase was so common and striking that it titles the article: "no me ponían mucha importancia" (27).¹ Demeaning treatment by the gatekeeper, nurses, and doctors had scarred the study's participants. "They experienced themselves as being easily dismissed, their concerns discounted or minimized, and their personhood rendered invisible by their undocumented status" (Chandler, et. al. 28). This "perceived discrimination" is not easily overcome (Chandler, et. al. 24). In fact, it appears to factor even more prominently than financial considerations into these women's calculations of when or if to return to the doctor. The natural response to medical workers' disregard was for the women to tacitly agree that they were unworthy of care. As a result, their rightful dignity disinclined them to follow-up visits, even if that reluctance brought unendurable pain. Returning to the doctor was nothing less than "an act of self-assertion," requiring the discernment to realize their true worth and the audacity to demand their right to treatment (Chandler, et. al. 29). Undocumented immigrants are often forced to choose between the right to dignity and the right to healthcare, a conflict that should never exist for any person.

Part of the difficulty in claiming those rights, as medical anthropologist Seth Holmes notes, is that they are not always apparent. His book *Fresh Fruit, Broken Bodies* uses the experiences of Triqui migrant laborers to illustrate a violence continuum, demonstrating that violence is neither merely physical nor mostly obvious. In fact, the danger of symbolic violence is its

subtlety. When abuses such as medical workers' insensitivity are gradually accepted as appropriate by all the individuals involved, the result is "the internalization and legitimization of hierarchy" (Holmes 89). The horrific truth is that many undocumented immigrants eschew the healthcare system because they have come to believe its insidious intimation that they are unwanted and unworthy.

Undocumented immigrants' sensitivity to medical rejection is not unfounded. Like all the sick and ill, their physical condition begets insecurities. One of Chandler's subjects, Imelda, is concerned that diabetes might compound her bruised finger into the amputation of her arm (Chandler, et. al. 31). When a medical professional flippantly dismisses her vulnerable state, her dignity becomes bruised as well (Ibid.). These immigrants' undocumented status further compromises their mental health when seeking care. Even waiting in line in front of a clinic known to serve the undocumented feels like a risky association with the identity they must always conceal (Ibid.). Thus, healthcare needs to be high-reward if it is to be worth the huge risk. Unfortunately, at least for certain elements of the population, that is rarely the case. For the Latinas in Chandler's study who persisted in acquiring medical attention, "the barrier to obtaining care... may lie, not in their reluctance to seek care...but rather in the inability of health care staff and providers to recognize and legitimize their medical problems when they do seek care" (Chandler, et. al. 33). If insufficient healthcare cannot be blamed solely on low request rates, then what else stands in immigrants' way?

According to Janet Shim, a paucity of cultural health capital is one answer. Extending on Pierre Bourdieu's culture capital theory, Shim identifies cultural health capital (CHC) as "the repertoire of cultural skills, verbal and nonverbal competencies, attitudes and behaviors, and interactional styles, cultivated by patients and clinicians alike, that, when deployed, may result in more optimal health care relationships" (1).

¹ Signifying that the doctors did not place a lot of importance on her or her situation. Thank you to Dr. Jared Patten for this translation.

Basically, CHC is the set of skills with which a patient's culture has equipped her to operate in a healthcare situation. The value of these skills or behavioral habits are determined by the prevailing culture. Shim identifies being knowledgeable and conversant about medicine, being aware of the information that matters to clinicians, being motivated and capable of improving health, being interested in the future, being attuned and adaptable to social cues, and being recognizable as a member of a desirable class as assets in the current American healthcare system (3). Much as economic wealth becomes concentrated through inheritance, cultural capital is handed down in a way that perpetuates the inequality (Shim 2). In Bourdieu's work, as in the vernacular, the upper class gets to make the rules of the game; Shim explains that "the distribution, transmission, movement, and exchange of cultural capital thus carry the indelible imprint of hierarchical domination" (4). Not only are the privileged born and raised to possess the valued skills, but the CHC-rich get richer while the CHC-poor stay poor. In Shim's terminology, "health benefits tend to redound to the resource-rich, and health risks to the resource-poor" (5). Because the privileged are more likely to learn about and implement new findings, advances in medicine only widen the gap (Ibid.). With limited experience in American society and even less in medical settings, undocumented immigrants lack the CHC essential to optimum treatment. They may never realize why they are receiving unsatisfactory results: some accounts of "perceived discrimination" may be due more to circumstances that deprive them of CHC than to the racial biases of their doctors.

But, while CHC theory relieves medical professionals of some accusations of discrimination, it implicates them in another way. CHC builds on itself partially because providers deem patients who display some cultural capital as worthy of receiving detailed explanations of their symptoms and gratuitous insights into the medical environment – new capital that can be

dispensed at future appointments – while those who do not (or cannot) supply a CHC down-payment are considered undeserving of anything more than the required medical treatment (Shim 8). To illustrate how good doctors can improve immediate and long-term outcomes by "actively cultivating [a patient's] CHC," Leslie Dubbin, Jamie Suki Chang, and Janet Shim share an anecdote about Iosepha, a Samoan woman (11). Originally, Iosepha neglected her medications because their benefits were not obvious enough to offset the headaches they caused. After listening to her patient's complaints, Dr. DeLuca replaced the headache-causing drug and developed a strategy to combat Iosepha's side effects. Then, she explained the importance of the drug regimen and enlisted Iosepha's commitment for two weeks. Iosepha cooperated and described feeling "control" of her medical situation (Ibid.). Her compliance and proactivity encouraged Dr. DeLuca, and the patient's increasing ability to communicate her observations clearly enabled the cardiologist to perform her job – caring for her patient's health – more successfully. Simply put, CHC cultivation can work.

Iosepha's story and others like it should inspire the medical establishment to make cultural health capital acquisition a priority. Medical professionals have a unique opportunity to compensate for the unequal distribution of CHC. If the purpose of medicine were only to diagnose physical illnesses or prescribe a particular pill, doctors would be justified in treating only tangible hindrances to health. However, since most physicians would agree (and most patients would hope) that the real goal is to improve a fellow human being's health, doctors should not ignore a cultural health capital deficiency any more than they would the harbinger of a disease. After all, if left untreated, both are proven to harm the patient's health. Putting a premium on the patient's overall welfare obligates medical professionals to sow

the seeds of CHC by investing healthcare guidance in even the most clueless patients and, in the meantime, to improve the range of their own cultural capital in order to ensure the highest quality of care. "Concordance," when patients and physicians are able to work together, requires "mutual recognition and matching of the social and cultural experiences, expectations and resources of *both* patients and providers" (Dubbin, et. al. 8). Ideally, patients and providers would meet in the middle; for the sake of success, they must meet wherever they can—even if that concordance requires a stretch on the physician's part.

The likelihood of a positive health outcome decreases significantly if physicians and patients cannot communicate in the same language. Even patients who can speak survival English—i.e., basic phrases—experience "cultural discomfort" in healthcare facilities (Hacker 178). Clinicians often try to resolve impaired communication through *ad hoc* translators: children who cannot understand the confusing medical concepts being discussed or bilingual medical professionals who are snagged from their primary duties to bridge a communication gap (Holmes 131). A 2004 study of interpretative services in healthcare facilities found that patients supplied with certified medical interpreters received a higher percent of the suggested preventive services (7.3% to 2.7%), participated in more doctor visits per year (1.74 compared to 0.71), and were more successful in getting prescriptions written and filled (Jacobs 867). Noting that the expense of interpreters would be at least partially offset if the more effective primary care prevented conditions from becoming severe, the report concluded that "interpreter services enhanced these patients' access to primary and preventive care for a moderate increase in cost" (Jacobs 867-8).

While translation services that increase patients' comfort and improve their outcomes would help to fulfill their right, the use of an intermediary should not need to be the norm. Since translators necessarily compromise patient

confidentiality and could impede a close patient-physician relationship by shifting responsibility for the patient's care, translation services should only be a stopgap measure while physicians acquire the attitudes and skills to serve all their patients effectively.

Though ambitious, such a scenario is not unimaginable. In a 2011 study, Helen B. Marrow of Tufts University describes the experiences of medical professionals in San Francisco's public safety-net program. As one of 60 sanctuary cities for undocumented immigrants, San Francisco prevents inquisitions about legal status, issues a municipal ID to promote access to social services, and allots funding for San Francisco Healthy Kids and Healthy San Francisco, initiatives that cover the primary-care costs of residents who are ineligible for state and federal welfare programs (Marrow 847). Although these programs are less comprehensive than other forms of insurance (852) and may unintentionally magnify the importance of cultural health capital by favoring "savvy" healthcare seekers (851), Marrow posits that San Francisco's unique approach "encourages and reinforces public safety-net providers' views of undocumented immigrants as patients morally deserving of equal care" (846). The city's strategy "helps public safety-net providers to translate their inclusive views into actual behaviors by providing them with increased financial resources," effectively creating "a legal-status-blind environment within the city's safety net" (Marrow 846-47, 850). Eduardo, a resident Marrow interviewed, reported that "voicing a view of unauthorized immigrants as 'undeserving' within San Francisco's safety-net is taboo; thanks to a strong and inclusive institutional culture, while 'you hear those things at the margins, the general reaction would be for people to say, 'We don't say that kind of thing here'' (qtd. in Marrow 850). Other interviewees attribute their "positive attitudes toward unauthorized immigrants" to "self-selection" (Marrow 848), which more or less guarantees that these professionals' personal

inclination had always been to serve the undocumented fairly. Unfortunately, not all doctors share their compassion, so replicating the sanctuary city's culture of inclusion in less hospitable locations will only occur if the powers that be initiate the reform.

If the medical establishment truly means what it says in its oaths and creeds, it will admit its error and espouse the cause of the undocumented immigrant. This crucial overhaul has several facets. For one, medical professionals and institutions should lobby for insurance reform and improved funding because financial constraints are doubly discouraging: preventing indigent immigrants from seeking care and deterring physicians from offering it to them. Drawing upon Eduardo's insights about his fellow residents, Marrow highlights the tension between money and morals when providing care to undocumented immigrants: "they have internalized the larger American public's concern about its fiscal costs and burdens, yet nonetheless 'agree that it's the right thing to do ethically, morally' as healthcare providers" (849). By properly reimbursing services for immigrants, the government could remove a significant barrier to treatment. However, it is unlikely to make such a politically daring maneuver without pressure from a medical lobby. Granting immigrants access to the healthcare system would enable them to begin acquiring cultural health capital, but even if the government acts on behalf of immigrants – and especially in the more likely event that it does not – the deficit will be insurmountable unless physicians make an effort to interact at their patients' level of understanding and contribute to it. The medical community should emphasize a right to healthcare independent of legal status and incorporate inclusivity and multilingualism into the education healthcare professionals receive. By articulating an expectation that doctors care equally for all patients and advising them to treat a culture health capital deficiency as vigorously as a disease, the medical establishment could

initiate a major change in the healthcare culture, but its efforts would be in vain if doctors refused to take the directives seriously. In order to prevent professionals from dismissing training as perfunctory and creeds as toothless, the medical establishment should uphold the standards it sets. Facilities should incentivize cross-cultural competency and humanitarian philosophies by valuing them in hiring decisions. In the meantime, an investment in medical translators would signal a commitment to immigrants' right to healthcare and jumpstart the acquisition of cultural health capital.

A comprehensive solution is clearly the best answer, but it is also the only one. Though the colossal reform outlined above may seem unlikely, small tweaks and stop-gap measures like the free clinic where I volunteer have no chance of breaking the vicious cycle of barriers that undocumented immigrants face. What we need – yes, what *we* need if we want healthcare to remain a human right rather than a token of social privilege – is a radical shift in consciousness in the medical community. Acknowledging that undocumented immigrants are people, not problems, the medical establishment should launch an intervention against the real menace to American healthcare: dehumanization.

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