Dispersed Bodies:
Becoming Patient in Rural Clinics in El Salvador

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This is a story about how remote bodies come to be diagnosable and treatable without conventional medical technologies. It's about the absence of bodies and medical technologies and the ways messengers, stories, obligations, and mobile phones come to be proxies for them. El Ocotal[1] is the last town in the northeastern corner of El Salvador—the paved road ends there. Although the road connects El Ocotal to nearby towns, the rough mountainous topography of the area, the poorly maintained roads, the lack of safe and affordable transportation, and the different waves of violence (civil war before, narco-trafficking now) make getting around the area a bit of a challenge. I arrive in the summer months, when the yellow and brown hills glow against the sunset, the dust rises, and the heat slows the afternoons. A few buses run from the hilly villages, passing through El Ocotal and neighboring towns to a small border city down the valley. In response to the infrequent and often unreliable bus service, returnees from the United States (US) have been ferrying small groups of people around the area in pickup trucks. More recently, a fleet of three-wheel motorcycles has began to move people between villages. But it is not only people that move through these transportation networks. These drivers and their passengers are constantly fetching information, delivering goods, representing friends, and saying what others tell them to say—they are constantly standing-in for others.

Despite a new public health clinic with improved facilities and three private clinics in

1. A pseudonym for the town I conducted four months of fieldwork in 2012.

El Ocotal, pharmacies are often the first place where people seek medical advice. Niña Gloria,[2] a nurse who came to work for the public clinic in the seventies and who now attends her own pharmacy, attentively listens to her patients or anyone serving as proxy for them. Medical consultations occur over a glass counter filled with high-movement pharmaceuticals: injectable analgesics, vitamins, birth control drugs, tonics, and antibiotics. When unable to visit the pharmacy themselves, people send messengers into town or farther away to neighboring cities to fetch goods, food, money, and information. Doing things remotely via proxies—neighbors, relatives, or local drivers—is quite common. Health care is no exception. These proxies narrate a list of symptoms and possible causes to the pharmacist and ask for medicine to get better. Children coming into town for school are often these medical-information messengers—they arrive with packaging containing drug information, notes scribbled on scraps of paper, and even memorized messages for Niña Gloria. Here, many bodies can relate symptoms to the pharmacist. Symptoms do not need to be authenticated by medical technologies nor need to be attached to the body that experiences them. Seeking health advice for a relative living in the US is not any different than doing it for a relative that is back in the village.

Doctors have increasingly come to rural towns like El Ocotal in eastern El Salvador—towns with high migration rates and remittances flows—to meet the demand for private care from elderly patients receiving remittances and, to the surprise of doctors themselves, to answer phone calls from patients' relatives living in the US. These relatives call for all kinds of medical advice, frequently seeking diagnosis, treatment, and the eventual shipment of pharmaceuticals sent via personal couriers, traveling relatives, or the postal service. These consultations generally happen over mobile phones with the aid of almost no other technology, save for rare images shared with doctors via social media sites like Facebook. Miriam, a woman who says suffers from "espolón en el talón" [heal spur] one day comes wobbling into the clinic not to see about her own problem but, rather, to inquire about her son's. She

2. All names are pseudonyms.

brings her mobile phone tucked in a pocket of her apron and tells me the doctor usually prescribes him medicine, which she sends with friends or relatives. It is this remote town that, ironically, provides health advice and treatment to migrants in global cities—not the other way around.

The possibility of diagnosis without laboratory exams, medical imaging, or basic bodily measurements is only jarring in a medical world where the biosciences primarily produce knowledge of disease. A clinic without a medical body produced through conventional medical technologies only becomes a conundrum when the body and its infinite biology are taken for granted as the most important objects of knowledge in medicine. In what follows, I explore a medical world without a physical *and* a techno-medical body. What does the medical encounter look like in the absence of a medical body made through medical technological devices and practices? What kind of medical body emerges when its physical presence and its biomedical information are limited, and what makes its diagnosis possible?

In the life I observe in El Ocotal, the condition of "remoteness" creates particular forms of interactions conducive to shortening distances through a multitude of relations. The idea of relaying medical messages, standing-in for others in medical consultations, and even playing the role of patients is commonplace. The physical body of the patient is constantly substituted by other bodies that can narrate their symptoms, pick up prescriptions, relay information. This form of enacting not physically present bodies seems to be a way of being in this town, not just a solution to the problem of remote patients. Bodies here appear to lose their individuality and operate through their connections with others. This "dispersed" mode of being particular to places like El Ocotal creates clinical conditions in which the biomedical body is neither whole nor individual. This is not to say that somewhere else the biomedical body can be whole or individual. From the study of science, we have learned that the "single human that forms the heart of humanism" is nothing but a composite "involving many measurements, numbers, intuitions, habits, humans—not to mention dead ends and (often unresolvable) contradictions" (Mol and Berg 1998, 476). Indeed, medical bodies and

diagnosis are multiple, produced through different knowledge practices of the pathology lab, the ultrasound exam, and the clinical encounter (Mol 2002). When remote patients come into the clinic I observe in El Ocotal, they come through a dispersed, not just multiple, set of relations that make their diagnosis possible.

I spend most of my time in El Ocotal at Niña Gloria's pharmacy and Doctor Cardona's clinic talking to patients and the many visitors that come to these spaces. Usually on Fridays at Doctor Cardona's clinic, it's impossible to find a chair—the waiting room is filled with older people exhausted by long trips endured on empty stomachs in preparation for blood tests. These days, at least one person is waiting to see the doctor in place of a relative living in the US. Like Miriam, other mothers and wives come to the clinic with their mobile phones tucked in their apron pockets to seek help for relatives needing health advice in the US. Miriam sits in the waiting room like any other patient. When it's her turn, she tells the doctor: "Vengo por mi hijo" [I come for my son]. She narrates the list of symptoms; but after a short conversation requesting more information, the doctor asks to speak directly to her son. At that point, she dials her son's number and hands the phone over to the doctor.

The physically present person at the clinic speaks for, or sits in place of, their relative in the US. In this case, Miriam both represents her son, as in "speaks for," and re-presents him, as in "making present again." When asked what brings her to the clinic today, she answers, "vengo en lugar de" [I come in place of]. When asked the same question, others say they are "pasando consulta por" [consulting for] their relative. I find their words compelling. They emphasize making their relatives present, standing-in for them, acting on their behalf. The doctor listens, and although he asks to speak with the patient who is feeling the symptoms, the relative standing-in for them remains crucial in the diagnosis and treatment. Miriam not only speaks his weight, height, allergies, and current suffering but also mediates the interaction. She creates a link that did not exist before and that could not exist without her presence. Doctor Cardona takes the call because he has obligations with the mother, not the son.

Doctor Cardona says it is not easy to make a diagnosis at a distance, but he reminds himself it's what he does every day. What he means, he explains, is that he makes the same kind of diagnosis every day with people he sees, hears, touches, and is able to treat. He says, "yo conozco estos cuerpos" [I know these bodies]. In other words, he knows the ailments of kinship groups. He abstracts the specific knowledge of "these bodies" to treat absent ones. He treats according to the knowledge accumulated in seeing and touching the cousins, uncles, siblings, children, parents, and the rest of the relatives of the person he cannot touch or see. The empirical body of the distant patient emerges here in two ways: first, in repetition, a form of kinship statistics, and next, in the "family predisposition" of kinship groups. Kinship groups become proxies for conditions that "run in the family." The medical bodies and health problems of kin groups stand in for the body of the absent relative. The kind of abstraction that Doctor Cardona uses is not any different than the medical knowledge practices that routinely abstract information from specific bodies. He constructs his own norms out of particular bodies he assumes to be similar to the absent ones. Instead of information produced by the comparison of measurements of large data sets, Doctor Cardona gathers detailed, and perhaps more relevant, observations from small meaningful groups. In this way, the observations drawn from kinship groups are proxies for the absent technologies and bodies.

Niña Gloria, the nurse turned pharmacy owner, also gets calls from migrants seeking health advice and pharmaceuticals. On one particular call Niña Gloria receives from a recently departed migrant, she spends most of the time investigating the living conditions of the woman calling. I could only hear Niña Gloria's questions and responses, but she fills me in on the details later. The woman calling is dealing with unexpected problems—her brother-in-law is cheating on her sister, and she is subject to brutal arrangements of debt and payment based on order of arrival. She gets the worst shifts and has yet to receive pay. Niña Gloria only eventually asks about her symptoms. She is exhausted, anxious, in physical pain, and cries all the time. Niña Gloria later tells me that to give health advice

you need to know the whole family, what they are like in the intimacy of their home, what they think of medicine, what they hope for, what they are willing to pay. Niña Gloria sends her vitamin B-12 and Diclofenac (an analgesic) in injectable form, along with more vitamins in several packages. In the absence of stethoscopes, pressure cuffs, and body examinations, the stories of migration, work, and family relationships become important tools to assess the health conditions of absent bodies.

Doctor Cardona's mother-in-law runs an *encomienda* business, a courier service. The noun *encomienda* can be translated as "care package," and the verb *encomendar* can mean "to give or send a greeting" or "to carry a package." Interestingly, it can also mean "to entrust" something to someone else.[3] Doctor Cardona's mother-in-law does not want to be interviewed, but his wife, who operated the business temporarily, shares the ins and outs of delivering *encomiendas*. The business, she says, is about transferring more than packages. Mothers in El Salvador ask about how their sons or daughters look when she delivers packages—do they look unwell, tired, skinny, pale? In turn, relatives in the US ask about what may escape photographs, letters, or calls; they want to know how relatives feel, are they sad, are they happy? The *viajero*, the local word used in the eastern part of the country for couriers, is entrusted not only with delivering packages but with being the eyes and feeling body of a mother or a wife. *Viajeros* delivering packages of medicine make important connections between relatives; they help relatives "see" and "feel" each other. In this way, the medical bodies of remote patients gain importance not only as medical bodies needing treatment but as relatives needing to be connected. The medical body of these remote patients is not only the biological body known through medical sciences but also the family relation seen and felt through the eyes of the *viajero* delivering medicine.

The phone, the most obvious proxy for the patient, makes possible the transfer of audio across space. It's the conventional telecommunication technology that enables the doctor to listen to what only experience of pain may communicate—a grunt, shallow and fast

3. The term also refers to the colonial institution in which Spanish priests or military men were given land grants containing a group of native people to serve as laborers.

breathing, a whispering tired voice. The phone remains an icon in telemedicine practices creating links and intervening in the relations they make. But the phone is not sufficient to make the remote patient present—it needs the mother that holds it, the doctor that exists because of the mother, the cousins that share a disease, the migrant stories that speak of risks, the couriers that see what can only be felt. These relations enact, bring into being, the remote patient. Mothers are proxies for their sons, kinship groups for genetic propensity, phones for narratives. All of these proxies function as medical "technologies" making possible the medical body—they stand in for medical history, illness narratives, medical statistics, and social conditions of disease.

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The "dispersed body" that emerges in El Ocotal echoes the distributed geographies and fragmented practices of diagnosis others have pointed out in their analyses of telemedicine (Mort, May, and Williams 2003; Mort, Finch, and May 2009; Cutchin 2002; Duclos 2015). But I use the term "dispersed" specifically to highlight the distribution of actions that enact bodies through many material devices and practices. What I point out is not only that those producing and reading medical data do so remotely but also that the notion of the singular patient with a body does not take priority in El Ocotal. Here, someone else can "go with my body" to the doctor. The issue is not so much about how the medical body of *a single patient* is made through material practices in dispersed locations but that there is, in fact, no single patient. When a patient comes to see Doctor Cardona, she is not coming by herself; she brings all her relations along as she walks into the clinic. The biological bodies of individuals are not the locus of disease. Bodies are family affairs, and as such, patients bring more than one body.

In the Salvadoran over-the-phone consultations, the medical body of the remote patient emerges outside standard biomedical practices and processes routinely inscribing the body on data, images, scans, charts. The doctors of rural clinics diagnosing Salvadorans remotely face a "double absence"—the materiality that touching *and* digitizing the body produces

is not available. Nevertheless, a materiality ultimately able to enact a medical body does emerge. In the medicine of Salvadoran remittance clinics, digitizing and visualizing through medical technologies is not the only way to make the body present and diagnosable. The body emerges dispersed through messengers, stories, obligations, phones—"techniques" in the Latourian sense as they intervene in the links they make and translate, compose, reveal and delegate (Latour 1994). The medical body of Salvadoran migrants is put together through intimate patient-doctor engagements, entangled in family relations, obligations, affects, money transfers, and trust. Numbers and measurements come through those entanglements making possible for a body to become diagnosable and treatable at a distance.

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