Remittance Clinics:
Making Relatives, Patients, and Doctors in Rural El Salvador.

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A los migrantes y sus familias.

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Abstract

Remittance Clinics:

Making Relatives, Patients, and Doctors in Rural El Salvador.

As Salvadoran migrants living and working in the United States send remittances to care for their relatives living in rural areas in El Salvador, a complex form of health and medical practices emerges to care for relatives as well as distant migrants. These migrants and their families circulate through medical markets drawn as much by global economic relationships of labor and technology as by complex family-making processes that involve money transfers, care obligations, and trusting relations. In this dissertation, I examine how medical practices in rural private primary care clinics in El Salvador become crucial enablers of family remittance networks and, in turn, exist through those relations. I study the dynamic coming together of the technological, familial, emotional, and financial aspects of making "remittance clinics"—sites and processes conditioned by migration and remittances in rural El Salvador. I argue that medical practices in remittance clinics are constantly negotiated and reconfigured through multiple interests enabled by remittances and the affective demands from migration, producing biomedical realities that do not always travel but constantly bring together relatives, patients, and doctors.

The remittances that circulate in these medical markets have fueled the creation of medical tourism projects sponsored by international aid organizations and the Salvadoran government. I analyze the economic and political global arrangements that produce remittance clinics and the ways their imbrication in family-making processes troubles their replication into corporate and state economic development projects. I look at the difficulties in attempting to reproduce the situated practices of remittance clinics and the business and state project failures that come about given their medical "excess"—their immeasurable and irreproducible effects that sustain their very existence.

This dissertation primarily draws upon science and technology studies and medical anthropology scholarship on clinical interactions, conceptualizations of the "medical body," and the study of practice as reality making process.

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Introduction

I first started thinking about the intersections of remittances and healthcare in El Salvador when one of my relatives, wide-eyed and unsettled, told the tales of some of his physician colleagues working extra hours attending Salvadoran migrants returning to El Salvador during the holidays. I was intrigued and surprised like he was and wanted to know more about who were these patients, what were they seeking, how were they paying, but more than anything, I wondered why were they coming. Perhaps our surprise was rooted in thinking that they shouldn't come to El Salvador, the place they had presumably left because it lacked healthcare, education, safety, and jobs. Our surprise may have had more to do with a perception that El Salvador lacks the latest life-saving treatments—it's not even on the map of healthcare development the way Cuba, Colombia, or Costa Rica are. Despite my relative's unwavering defense of the quality of medicine offered in state-managed healthcare, his personal contribution to developing medical programs in the country, and his unwillingness to abandon the country even when he was the target of death squads in the eighties, when his own son lay dying in the best state-managed ICU, from a preventable but endemic disease, he considered seeking medical care out of the country. It's impossible to know if the complications of his acute disease would have had a different outcome at a hospital where extreme life-saving procedures with seemingly unlimited resources and cutting-edge technology are the order of the day. However, a sense conjured by a colonial and developmentalist imaginary tied his fate to the reality of El Salvador as a country in the margins of development. Asking why Salvadorans were returning to seek healthcare in the place they had left to begin with, seemed to be an irony worth investigating.

Salvadorans started leaving El Salvador even before the massive civil war displacement of the eighties began, which accounts for much of the remittance and healthcare circuits that have made possible doctors working extra hours during the holidays. In the first half of the 20th century, displaced farmers and out-of-work laborers left for Honduras seeking jobs in the banana plantations of the United Fruit Company, and access to land

in the yet-to-be-ploughed state-owned fields of the neighboring country. Salvadorans like my grandfather, born in a small town known for its artisan clay figurines, and my grandmother, born in a Honduran mountain town bordering El Salvador, left their hometowns to work for the largest employer in the region at the time. During World War II, a significant number of unskilled Salvadorans left for Panama and the United States (US) to work in the expansion and operation of the Panama Canal and the farms and factories hungry for workers in the US. But the Salvadoran migrant networks that have made possible the dynamic transnational community of today, did not start until migration increased in the decade of the seventies. During this decade, as political destabilization resulted from military conflict with Honduras, repetitive electoral fraud, and increasing state repression, Salvadorans started to arrive in the US in great numbers, creating migrant paths and sites that would prove crucial in the explosion of migration the following decade. During the civil war of the eighties, Salvadoran displacement amounted to more than half a million people in a country of merely five and a half million at the time. Salvadorans left the country en masse and have kept on leaving as the economic promises brought by the end of the conflict vanished. In the mid-nineties, when the promise of a better life announced by the 1992 peace accords did not materialize, Salvadorans continued to leave, now following well-worn paths created by those that had left a decade earlier. Although migration has waxed and waned since the high rates of daily migration of the mid-nineties, Salvadorans continue to leave today even in the face of heightened anti-immigrant sentiment in the US and Europe.[1] If judged by the amount of people leaving and the stories of narrow escape and survival, El Salvador is a place to abandon, not to return to.

No longer are people fleeing the devastation of the January earthquakes of 2001, the destruction of hurricane Mitch of 1998, the economic pressures of the nineties, or the state repression of the eighties. More recently, children escaping from the grip of ever-increasing organized crime and gang violence in their neighborhoods have joined the long

1. Most Salvadorans have migrated to the US, but significant communities exist in Canada, Italy, Spain and Australia. Reliable figures on migration are difficult to obtain given the unauthorized condition of travel of many migrants. The Salvadoran government calculates 2.8 million people born in El Salvador now reside elsewhere (Ministerio de Relaciones Exteriores, Press Release, May 13, 2010), while the United Nations Population Fund considers only 1.2 million do so (CELADE 2014). The estimated net emigration rate is -6.2 percent for the 2015-2020 quinquennium (CEPALSTAT http://estadisticas.cepal.org/).

list of those that have left before them. With one of the highest homicide rates in the world and one of the lowest in hospital resources,[2] unsurprisingly, more Salvadorans seem to want to leave—a 2014 public opinion poll found that 33 percent of respondents wanted to migrate, a 16 percent increase from the previous year (IUDOP 2014, 84). Why would anyone, let alone Salvadorans, seek healthcare in a place so well known for expulsion of its citizens? The enquiry that conceived this dissertation was not about whether global health customers wanted to receive care in high-tech well-equipped clinics in San Salvador, or why would Salvadorans want to return to visit their communities, but why would Salvadoran migrants in particular want to receive healthcare in the country they had ran away from.

Asking why Salvadorans return to seek healthcare in El Salvador lead me first to the advertisement of health services directed to Salvadorans living in the US. Through this advertisement—found on the internet, airline magazines, the Salvadoran airport, and health fairs—I learned there was a concerted effort to sell health services to Salvadorans abroad made by development organizations such as the US Agency for International Development (USAID) and Salvadoran government organizations dedicated to facilitating and promoting trade and investment. The ads were part of development initiatives that in 2006 had begun to promote health tourism in El Salvador as a way to multiply high-skilled service jobs and to diversify exports. These organizations contented Salvadorans abroad were the "natural" entry point into larger transnational markets given they were already coming to receive care when they visited their families. Institutions ranging from the Salvadoran consular network, to multinational financial insurance companies, to remittance service providers, to development agencies have become involved in the process of selling health services to Salvadoran migrants. Throughout the last decade, a diversity of products has emerged at the intersection of remittances and health; products like health advice calling cards, health checkups for visiting Salvadorans, pre-paid health plans for those in El Salvador, consultation packages sold at remittance transaction points have appeared

2. In 2012, El Salvador had the fifth highest homicide rate in the world, and the fifth lowest hospital bed ratio in Latin America. The estimated homicide rate per 100,000 people was 43.9 in El Salvador, and 103.9 in Honduras, the highest rate in the world (WHO Global Health Observatory). That same year, the hospital bed ratio per 1,000 people was 1.06 in El Salvador, and 6.21 in Barbados, the highest in the region. Cuba had a ratio of 5.33, while the US of 2.9 (PAHO Regional Health Observatory).

and disappeared as the lure of remittances responds to shifting political and economic climates.

At the start of 2012, after spending three months in Los Angeles tracing health projects designed for migrants and their families, I began visiting some of the medical groups promoted through the health tourism project envisioned by USAID and the Salvadoran government. I interviewed the directors of these enterprises at their clinics, and toured their quiet, modernized, well-equipped facilities. I entered these spaces asking why were Salvadorans coming, what else was motivating their travel besides the obvious cost advantage, medical quality, and cultural familiarity that health tourism projects were promoting? Soon, I realized that there was a schism between the patients that were "already coming to receive care" and the patients that medical tourism envisioned and planned to attract. By following the path of remittances, I ended up in rural clinics where I met Salvadorans returning to receive health services in seemingly improvised and precarious setups, in which a complex dynamic of doing medicine occurs. This dynamic would require a different kind of question. Asking why, assumed there was something that motivated travel, something that existed before travel. The question took the object of desire for granted. It sought a logic constituted in the object that motivated movement, but never opened the object to examination. But the dynamic of doing medicine I found in these rural clinics defied such type of analysis. Remittances and travel are also *making* the healthcare Salvadorans are coming to receive. The rural clinics I visited emerge out of the remittance economy of migrants and the family relations these bring into being. Medicine in these rural clinics enacts the family obligations remittances carry, through the purchase of care, and, more interestingly, through the negotiations of medical practices that bring doctors, patients, and relatives into relation.

I had to start writing this dissertation to realize the shortcomings of asking why. During fieldwork, it was my favorite question to ask. I asked patients, doctors, nurses, health aids, government administrators, why did they think Salvadoran migrants were coming to whatever clinic I happened to be at. After a while, I was just asking why anyone came to the clinics I visited. Patients offered opinions about why they liked this particular doctor

and what they hoped to get from him, but also about why they disliked the public health clinic, or other doctors they had seen before. Sometimes they took the opportunity to denounce their terrible experiences in the public clinics and hospitals with great intimacy of detail, sharing their despair and rage with me. With their responses, I drew a map that correlated perception of pain and severity of disease to a hierarchy of healthcare services based on a combination of cost and trust. Without realizing, I had drawn a 1950s model of health-seeking behavior, which "hypothesized that perceived susceptibility to a disease and perceived severity of that disease, combined with perceived benefits of preventive actions minus perceived barriers to taking those actions, explained the likelihood of an individual taking preventive health measures, complying with prescribed regimes, or utilizing medical services" (Good 1994, 41). The model has come undone because, according to Good, "its limitations result from [its] narrow conception of culture and human action" (41). But for me, the shortcomings of the model were not a problem until the complex dynamics of the way medicine is done in the rural clinics I visited became a "black box" (in the idiom of the sociology of science), in which differences to scientific medical practices were reduced to cultural beliefs, posed as obstacles to compliance and utilization of biomedical services. This type of questioning explained the motivations of travel in terms of the historical and cultural perspective of Salvadorans (the subjects), and left the medicine they sought (the objects) inside the black box.

The complex dynamics of doing medicine in the rural clinics I visited did not become evident until I started writing and thinking through a different kind of questioning. Inspired by the work of science and technology studies (STS) (e.g. Latour 2005; Law 2004), especially the work of Annemarie Mol (2002), I started asking, what do medicine and remittances do in these clinics. How are medical bodies enacted? How do medical bodies emerge without medical technologies? By focusing on action, I was following a strain of STS that has made "possible to refrain from understanding objects as the central points of focus of different people's perspectives. It is possible to understand them instead as things manipulated in practice" (4). In the practice of doing, objects come into being. By foregrounding action and practices, this vein of STS shifts social science enquiry from focusing

on "how do we know reality?" to "how is reality made?" This kind of framework allowed me to think through what kinds of realities are *made* in rural clinics—what kinds of doctors, of patients, of relatives are being enacted. It allowed me to pry open "the clinic" to the dynamic processes that make it. These clinics offer what is undoubtedly biomedicine. Doctors trained and certified in Salvadoran medical schools, which follow standards imposed by international and local agencies, service the small-town clinics I visited. But by putting my field notes through this kind of questioning, medicine began emerging as something negotiated and contingent on the materiality of the clinic, and the comings and goings of remittances and families that sustain them. This dissertation is about what is made in the "medical encounters" that occur in these rural clinics—encounters not only between patient and doctor, although much of the dissertation is dedicated to that, but also between migrants and relatives, doctors and charlatans, stethoscopes and kinship groups, treatment and touch, remittances and health. In paying attention to actions and practices, a particular reality of family, of medicine, and of remittances slowly emerges.

I argue that biomedical clinical practices are constantly negotiated and reconfigured through multiple interests enabled by remittances and the affective demands from migration, producing biomedical realities that do not always travel but constantly bring together relatives, patients, and doctors. The medical markets through which traveling Salvadoran migrants and their relatives in El Salvador circulate, are not only drawn by usual global geopolitical and economic relationships of labor and technology, but also by the complexity of the processes that make families transnationally. Medical practices and services are crucial in the complex process of making families across political borders, long periods of separation, insecure remittances, and uncertain futures. The clinic instantiated when Salvadorans in rural areas go to the doctor to engage distant relatives, or when they demand treatment practices that exceed biomedical standards, or when they pay with remittances, is what I term a "remittance clinic." I call these clinics "remittance clinics" to highlight the conditions of possibility remittances create, and to evoke the sense of obligation and care contained in them. The term also intends to refer to the process that enables the dynamic coming together of the technological, familial, emotional, and

financial aspects of clinics conditioned by migration and remittances in rural El Salvador. This dissertation is about clinical interactions in remittance clinics, and the ways these are involved in transnational family-making processes.

This investigation draws upon science and technology studies, and medical anthropology scholarship on clinical interactions and the formation of the "medical body." My examination of the clinical interactions in remittance clinics hopes to add to accounts of "differences in medicine." It contributes to works that argue, "medicine is not a coherent whole. It is not a unity. It is, rather, an amalgam of thoughts, a mixture of habits, an assemblage of techniques. Medicine is a heterogeneous coalition of ways of handling bodies, studying pictures, making numbers, conducting conversations" (Mol and Berg 1998, 3). The first three chapters converse with investigations that focus on "[Medicine's] practices and performances: the manipulation of fluids and numbers in the laboratory, the physical examination of suffering patients, and the filling out of forms" (3), the doings of medicine in different regimes of knowledge. This dissertation contributes specially to studies about how medical practices are contingent on and negotiated with *patients*, not only other experts as has been the focus of much work in STS. I examine the doings of medical practices in remittance clinics as specific scenarios that produce situated practices. I investigate ethnographically how medical bodies emerge when patients are diagnosed over the phone without any other technology, how relatives come into being in remittance clinic encounters, and how doctors are made in the clinic through the negotiation of prescription practices, translation, and affection.

Many scholars have already said that migration in El Salvador has dramatically affected every aspect of everyday life in the country. When estimates of migrants range from at worst 1 in 3 (PNUD 2005, 38), to at best 1 in 5 (CELADE 2014), it's hard to think of what has not been affected by migration. Studies that highlight the dynamic and complex intervention migrants have in the daily affairs of their families and communities make those numbers seem even more dramatic. Their absence and continued connection have profoundly impacted social conditions ranging from wage competition, to consumption patterns, national sense of belonging, family configuration, cultural identity,

and collective aspirations. A large number of academic books have examined the effects migration has had on the configuration of families (e.g. Baldassar and Merla 2014). The scholarship on family reorganization in El Salvador has drawn a complex picture of transnational family life that defies simple representations of the so-called disintegrated families deemed culpable for incorrigible youth ready to join gangs on both sides of the border (Andrade-Eekhoff 2003; Benítez 2011, Ch 2; PNUD 2005, Ch 7). My work does not focus on "the family" either as pillar of the reproduction of capitalism, moral social necessity, or fundamental social structure. My focus is much more narrow. I examine how kin obligations materialized in remittances are part of the "practices and performances" of clinical interactions. I investigate how clinical interactions produce and are produced by kin obligations. I use "remittance clinics" as a lens to study the change remittances and migration bring about in the processes of making relatives.

In chapter 1, The Body Dispersed, I ask how doctors in remittance clinics diagnose and treat patients that come into the clinic through the mobile phones of their kin. When Salvadorans living outside the country are sick, sometimes they call their kin in El Salvador, who in turn seek advice at the local private clinic that has become part of the care they buy with remittances. I look at how the clinical interaction happens when the doctor takes the call, and how the doctor diagnoses and treats the medical problem of remote bodies. Doctors diagnose and treat callers *without* the classic technology that makes possible remote diagnosis, such as images and measurements that can be transferred through telecommunication technology. The medical body of these callers emerges, nevertheless, through the biomedical materiality shared with their kin, through their medical history told over the phone, and through obligations between doctor and kinship networks. The mobile phone and kinship relations become "medical technologies" making possible remote diagnosis and treatment. At the same time, these mobile phones literally *stand in* for the absent relative. As such, mobile phones exceed their role as medical or communication technology, and become actors in kinship networks. In this scenario, the medical body is not a coherent whole individual body, but rather, a *body dispersed* through multiple relations that make its emergence possible.

The patients coming to these rural clinics are mostly the dependents of remittance senders—parents, grandparents, spouses, and children. Sometimes siblings, godchildren, or other relatives they have obligations with also come to the clinic. In one of the rural clinics I visit, a doctor tells me:

> Este es un pueblo de viejitos, [. . .] la mayoría de pacientes si se fija usted, son adultos mayores y niños, los niños no son hijos de ellos, son nietos, porque los papás están en Estados Unidos y los que vienen son abuelos.
>
> [This is a town of old people, . . . the majority of patients if you notice, are seniors and children, the kids are not children, they are grandchildren, because the parents are in the US and the ones that come are grandparents.]

The clinic becomes an important place where older patients, with support networks unable to physically share the everyday troubles of getting old, continue to make a social life. In the clinics I visit, older people demand to be *reckoned with* by demanding time and thorough clinical exams, by demanding prescriptions, and by demanding treatments that exceed biomedical standards. Chapter 2, Becoming Present, examines these kinds of interactions by thinking through what patients ask medicine to do in this context. This chapter explores how rural Salvadorans with relatives in the US use the urgency of the medical space to sustain their presence in the lives of those who left, and also, importantly, to reaffirm their own being in their local lived social space. To "become present" in other people's lives becomes an exercise in making them act, making them do things, making them do things for/with you. The chapter investigates the way "medicine" becomes a site to make relatives act, to elicit a response, to affect. I conceptualize medicine in this chapter as a crucial actor capable to demand actions from others, who may need such dramatic demand as ties with relatives weaken through the passage of time, and through the establishment of new ones outside the country.

What I find most interesting in the doctor-patient interactions in these clinics is the doctor's willingness to "adapt" and "accommodate"—in the words of one female doctor. The accommodation and adaptation doctors and patients do, evokes the steps of a complicated dance in which both patient and doctor learn to "get closer." Many of the patients that come to these rural clinics name their health problems and bodies in ways

that doctors at first do not understand, they also request specific therapies that exceed biomedical standards, and expect examinations to be filled with affection and emotion. Doctors do not reject, ignore, or outright challenge these requests. They acquiesce without completely stepping out of their own choreographed biomedical regime of knowledge and without betraying oaths or ethics—at least not the ones they have set for themselves in this dance. Chapter 3, Making Doctors, thinks through these scenarios by asking how doctors are enacted in these adaptations and accommodations. By asking how doctors are made, the chapter investigates these interactions without submitting them to overarching logics that would render these practices to be a form of charlatanism. It seems patients are not questioning the authority of medicine, on the contrary, they are asking for "more medicine." Doctors come into being through these requests for "more medicine." Doctors respond to patients, and in that responding, they are made.

When doctors cannot solve health problems in these primary care clinics, they refer patients to specialty clinics and hospitals located in larger towns and cities. The way these referrals work is not at all transparent. Sometimes they are the result of formally arranged professional relationships in which doctors receive benefits in the form of payment, access to facilities, or reciprocity. Other times, doctors refer patients to colleagues they trust and personally know through long-term friendships. Patients from rural areas end up in specialty clinics and hospitals in neighboring towns, large cities, or the capital, San Salvador. The rise of these specialty clinics and small hospitals is what caught the eye of development agencies like USAID, and what gave momentum to a multitude of projects wanting to capture "medical remittances."

In El Salvador remittances have had an enduring allure, they have come to be perhaps the most powerful source of imagining futures. Remittances started to transform the economic landscape of the country at the beginning of the war, as cash payments arrived through migrant networks into the foreign exchange black market. Since those days, remittances have dramatically transformed Salvadoran political, economic and social arrangements from being based on coffee production and export, to being based on labor export and remittances. The case of El Salvador has been the subject of numer-

ous investigations addressing the issue through a wide range of optics and disciplines. The work of anthropologist David Pedersen (2013) stands out for its approach to frame the transformation as part of a hemispheric phenomenon in which the US has changed from being a country dominated by industrial manufacturing, to one now much defined by the production of services and high-tech goods. In *American Value*, Pedersen examines "the appearance of this reality in El Salvador, where there is great significance and meaning in the US-bound migrant and their transfer of wealth from the United States back to El Salvador" (193). It is in the great significance of migration and remittances that I'm also interested, the significance constituted in the transformation of remittances into "interest-bearing capital" motivated by promises of development. More precisely my work is concerned with the power remittances have to invent projects based on expected "natural" flows of remittances. The collection of remittance data plays an important role in performing this "natural" flow and expected growth. Economists like to compare remittances to foreign direct investment, foreign aid, gross domestic product, or exports to show their overwhelming dominance against those indices. In this way remittance measurements are made to tell a story of economic potential (see Coutin 2007, Ch. 5; Hernandez and Coutin 2006). Statistics such as the 3.5 billion in remittances received in 2006 (18.71% of GDP), and their increase to 4.3 billion in 2015 (16.52% of GDP), perform a certain sense of capacity and economic importance. The powerful narrative of remittance-led development in El Salvador brings about initiatives like health tourism, through the advice of international development agencies promoting neoliberal reforms at the end of the nineties.

Chapter 4, Medical Tourism for Salvadorans Abroad, examines two cases born out of the momentum of the promise of remittance-led development, which never got off the ground or eventually failed to become sustainable. It analyzes the case of a string of health plans sold in the fashion of medical tourism, and the case of health insurance sold by the state-managed social security system. I contextualize the desire to capture remittances in health projects as part of global rearrangements of biomedical search and access produced within political-economic configurations of globalized biomedicine enabled by

the imaginary of remittances as free-flowing capital—capital unencumbered by borders or tariffs, and conceived as limitless. The chapter focuses on the ways the projects are not able to link health to remittances in their attempt to offer anonymous, institutional, and standardized care designed to fill the health needs of migrants and their families. Speculating that the intended market originates in the rural clinics I visited, I suggest that remittance networks have edges; they do not endlessly flow to fill "unmet needs." In these cases, attempts to link remittances to health fail perhaps because the work medicine does in remittance clinics cannot be translated into projects that do not have an interest in "making relatives." What medicine and remittances do, and what they can invent, is not only determined by the regimes of knowledge that invent them (medicine and economics), or the geopolitical conditions that shape them. In the Salvadoran life I observed, their linkages depend not on the promise of economic growth or development, healthy outcomes or positive measurements, but on the promise of creating and maintaining relations.

A Note on Tense

From this point on I use the present tense when talking about the things that happen during fieldwork. I write "I interview," and "Doctor so-and-so says." I use the "ethnographic present" to make clear some of the stories that contain multiple events happening at different times. The time of the interviews, the time of participant observation, and the overall time of fieldwork will be written in the present tense. Writing in the present also brings my fieldwork into the present moment, literally moving it from the time it happened to the time of writing. This purposeful moving of time is a gesture to attend to the kinds of transformations Marilyn Strathern (1999) suggests fieldwork undergoes at the time of writing. Using the present forms part of my attempt to "re-create some of the effects of fieldwork itself" (1).

Remittance Clinics in Context

After spending three months in Los Angeles, I start interviewing doctors who have modernized and expanded their services with the specific intent to attract Salvadoran migrants and their families. These doctors head medical groups offering a variety of specialized

medical services in cities outside San Salvador. Later, I arrive at clinics in small rural towns where doctors work alone offering primary care with the minimum medical necessities. These medical services are private, meaning patients pay with their own funds and the state government does not manage or finance the service. Healthcare availability and organization in El Salvador is similar to that of other Latin American countries. Through their own separate infrastructures, the public health system, the social security system, and the private health system offer most of the healthcare available in the country.[3] The Ministerio de Salud (MINSAL, Ministry of Health) offers universal care by law, but, by design, it intends to cover the health needs of only those who cannot access the social security system, or enter the private market. In practice, the MINSAL cannot fulfill its legal mandate to guarantee access to its target population. According to the World Health Organization (WHO), in 2007 the MINSAL was able to offer care to only 40 percent of those who needed access (PNUD 2007, 205).

The 2009 Health Reform puts forth a centrally-administered community-based strategy to provide health more equitably. The Equipos Comunitarios de Salud Familiar (ECO), are meant to find "local solutions to local healthcare problems," in the tradition of *promotores de salud* (health aids), enlisting locals to survey their community, and to help in the promotion, prevention and delivery of medicine and rehabilitation (MINSAL 2011, 9). Their slogan *La salud llega a tu familia* (Health reaches your family) is a literal reference to the new spatial distribution of health services—it arrives at the doorstep of your home. By bringing healthcare to homes in remote areas, the state means to address the problem of accessibility in rural areas, where distance might be short, but the lack of roads, unavailability of safe public transport, and unrelenting tropical storms in the winter makes going to the public clinic difficult. The ECOs only service municipalities the state categorizes as "extremely poor" or "poor," and are present in all the towns and villages I visit.

In the rural areas where I conduct fieldwork, a public health clinic is always present and many of the doctors who have their own private practice work in the public clinic

3. The military has its own independent health infrastructure, and public school teachers have their own insurance which contracts services in the private sector.

simultaneously, or have done so in the past. Although prohibited by law, doctors in the public health system often ask patients to buy their own medicine, or suggest they go to their private clinics for exams, therapies, or procedures not available in the public system. When accompanying the people I live with to the public health system, I witness such requests and even become the one sent to buy the medicines. Although the government condemns and outlaws the practice, doctors complain the ever-present scarcity of pharmaceuticals and hospital materials force them to ask patients to buy their own medicine or finance their own lab tests. Shortages, even when not any worse than in previous government administrations, become contested political matters, whose root causes often become forgotten in the finger-pointing write-ups of the press (i.e. *La Prensa Gráfica*, Sept 20, 2010).

The Instituto Salvadoreño del Seguro Social (ISSS), the national social insurance system, is funded through the compulsory contributions of employers and employees in the formal economy, but it also receives a small yearly budget from public funds. It covers salaried workers, their spouses and children under 12, and pensioners. By law farm workers and seasonal workers continue to be excluded from contributing. Its hospitals and clinics concentrate around urban areas in large cities, and a significant number of primary care clinics operate inside work facilities—a reminder of the pro-labor post-World War II initiatives that gave birth to the system. In the rural areas where I spend most of my time, there are no ISSS facilities and no one I interview has access to its services, either as an active contributor, beneficiary, or pensioner.

The vast majority of the population uses public health services or social security health services when they decide to treat their health problems outside the home. The ISSS reports it covers 25 percent of the total population (counting active contributors, pensioner contributors, and beneficiaries) (ISSS 2015a, 18). But this does not mean all members use the system. Many middle-class workers only use ISSS services for expensive, chronic, or emergency care, and use private services when visiting GPs or specialists. The 2014 Encuesta de Hogares de Propósitos Múltiples (EHPM), an annual survey conducted by the statistics and census administration, found that among those that sought care,

62 percent did so in MINSAL facilities, 17.1 percent in ISSS facilities, and 15.8 percent in private clinics and hospitals (DIGESTYC 2014, 19). Although I spent time in public health facilities and have many stories to tell, the work in this dissertation is exclusively focused on what happens in private rural clinics.

I begin fieldwork in El Salvador by interviewing directors of medical organizations who advertise their services to Salvadorans living in the US on the Internet, in airline magazines, at the Salvadoran airport, and at health fairs organized by the Salvadoran consular network. I interview these directors in their facilities, usually small hospitals with operating rooms, in cities outside San Salvador. Directors candidly share the history of their organizations, the local politics of healthcare, and the challenges they have when marketing their services to Salvadorans living abroad. But when I ask if I can speak to patients coming from abroad, they hesitate. They tell me that it will be difficult for me to interview them because they come so sporadically. After having little success talking with patients in these clinics, I go to smaller cities and towns with high rates of migration and remittances and from there, follow patients to smaller towns and villages where I find private primary care clinics. As opposed to the directors of medical organizations targeting Salvadorans abroad, the doctors in these small private clinics and hospitals are quite forthcoming about their interactions with Salvadorans living in the US and their relatives. Most do not advertise their services, much less target the Salvadoran diaspora directly. They talk with surprise about their interactions with traveling Salvadorans—these encounters are not something they have engineered their services upon, and thus engage patients from abroad with a degree of reluctance and personal conflict. Yet, the very existence of their clinics depends on the dynamics of remittances. Although their services may not be "engineered" on providing services for Salvadorans coming from abroad, these small clinics and their doctors are inevitably imbricated in the circulations of remittances and the relations these bring about.

The travels of Salvadorans living in the US to rural clinics in El Salvador reflect arrangements quite different from those that result from the demands and aspirations of medical tourism promoted by corporate and governmental institutions. The small clinics

where Salvadorans arrive are not the product of large capital investment, equipped with the latest medical technology, or geared toward maximizing patient comfort. The clinics these Salvadorans visit are typical rural clinics—usually operated by a single doctor without support staff in a rented room or small house with only the basic medical equipment necessary to offer primary care (Figure 1). In these clinics, far away from the "'super specialty' marble and glass corporate hospitals" of the Indian health tourism Harris Solomon (2011) studies, or the "boutique" hospitals in San Salvador catering to Salvadorans abroad or the local elite, doctors work for themselves in often difficult conditions where what lacks seems to be more evident than what they have. Some don't even have running water, and those that do must collect it as it does not run all the time (Figure 2). Yet, these clinics do something special for Salvadorans, and become crucial in the family-making process of families separated by migration.

Figure 1. Private clinic exam room in small rural town. All pictures taken by the author in 2012.

The number of clinics in the town I call El Ocotal, where I do most of my fieldwork, went from one public health clinic and one pharmacy before remittances, to three private

Figure 2. Private clinic bathroom area in small rural town.

clinics, two labs, and four pharmacies after. I find this to be typical in towns with similar remittance demographics. These primary care clinics feed into recently established secondary and tertiary care in nearby cities and towns. In these rural primary care clinics, doctors often have to attend births, respond to small trauma emergencies, diagnose appendicitis without blood or ultrasound exams, and many other medical problems that require them to do a bit of everything. Today, the city closest to El Ocotal, an important regional trade center of imported apparel and domestic wares only ten miles from the Honduran border, is saturated with specialty clinics ranging from pediatricians to cardiologists to oral surgeons. The visuals are impressive, signpost after signpost crowd business entrances, tops of buildings, posts, sidewalks, billboards, and any wall space nearby (Figure 3). The family I stay with in this city tells me it did not use to be like this—only a secondary care state hospital and a public clinic serviced the area. Now private specialty clinics and pharmacies crowd the city center, and two small private hospitals flank its entrance.

Figure 3. Saturation of signposts for small private clinics in a small city.

Patients pay cash for most services, and by-and-large no insurance mediates referrals and visits. No organized networks of doctors determine patient flows either, although pre-paid health plans and credit-union-sponsored health services are starting to approach doctors to form new networks and join more established ones in the capital. In both, the rural primary care clinic and the specialty clinics in nearby cities and towns, doctors tell me the vast majority, if not all their patients receive remittances. Those involved in more expensive procedures, like surgeries or hospitalizations, many times make payment arrangements over the phone with relatives sending payment through remittance institutions such as Western Union. Not surprisingly, remittance service providers and medical establishments many times share the same dwelling (Figure 4). All the rural towns I visit offering private medical services have a Western Union or a bank office able to dispense remittances (Figure 5). In San Salvador, pharmacies have become the de facto place to receive remittances and make a variety of financial transactions such as mobile bill pay-

ments and even payments of state-owned utility services. Most of the doctors I talk to in this area say the emergence of medical specialties and hospitals in small cities and towns, and the establishment of two state-of-the-art hospitals in San Miguel, are a phenomenon linked to remittances.

Figure 4. Pharmacy and Western Union in same establishment.

Figure 5. Western Union next to dental clinic, laboratory, and hospital.

Many of the health professionals and patients I interview talk about the use of remittances to pay for health services as a matter of fact, an indisputable reality made evident in the buildings that weren't there before. Many people, from anonymous companions in long bus rides to restaurant hosts to formally interviewed patients and doctors, have a story about health that involves remittances. The data coming out of the annual EHPM seem to show a direct relation between the number of households receiving remittances and the percentage of sick seeking private care (Figure 6). Private medical visits are not rising steadily; they fluctuate at the rhythm of remittances. A few of the specialty doctors I interview in small cities say they have perceived a decline in medical visits overall and think unemployment caused by the global economic crisis of 2008 may be at fault.

I use this graph here to perform the reality this dissertation is concerned with. While remittance data performs the narrative of development through numbers made to dazzle economists and politicians, in El Ocotal remittances have their own legend. People here talk of a time before remittances, and a time after remittances, but their moment of revolution in the nineties has passed. Now remittances ebb and flow along with the many markets they instantiate.

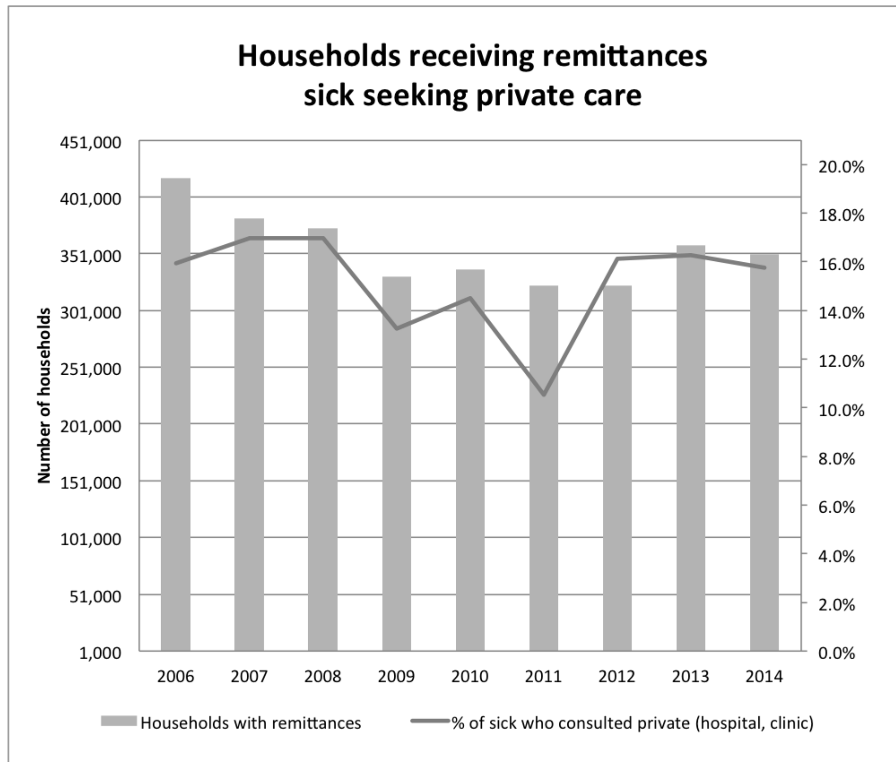

Figure 6. Source: Own elaboration using EHPM 2006-2014 data provided by Ministerio de Economía, Dirección General de Estadísticas y Censos. Data published by institutions are estimates drawn from population sample.

The rural clinics I visit offer family primary care in the most basic settings, with little equipment, comfort, and advertising, financed through remittance dollars coming in the form of cash payments for medical visits. The flows of bodies and capital drawn in this remittance medical market do not always pass through the clinics and systems that have been created specifically for "medical tourists." Instead, patients and remittance follow intimate paths of family, friendship, and professional medical relationships. Migrants in the US call doctors their mothers or sisters recommend, and their mothers go to the specialists

their family doctor personally knows. This dissertation is about the relations enacted in those intimate medical networks, the clinical interactions that make them possible, and the edges remittance networks have when articulated through those relations.

Chapter 1

The Body Dispersed

ABSTRACT. The rise of new information and communication technologies in the first decades of the new millennium has widened the possibilities of remote diagnosis, treatment, monitoring, and patient care in biomedicine. Telemedicine, conceived to reach patients in inaccessible areas with the advent of World War II communication technology, has given way to a diverse array of clinical interactions enabled by sophisticated medical and communication technologies, and patient use of digital media and devices. According to proponents of telemedicine, new technologies promise to make distance between health provider and patients irrelevant, reduce cost, and increase access. In El Salvador, another kind of remote diagnosis is taking place. Salvadorans living and working in global cities in the US, such as New York, Los Angeles, and Washington DC, call primary care doctors in the rural villages where their kin live. In contrast to diagnoses highly mediated by communication and medical technologies, rural doctors remotely diagnose and treat Salvadoran migrants with only a mobile phone. Drawing from local rural practices of interaction and communication, and conceptualizations of "the body" in clinical practice in science and technology studies, I suggest the medical bodies of Salvadorans living in the US emerge in the rural clinic in a dispersed way—through the biomedical materiality shared with their kin, through their medical history told over the phone, through obligations between doctor and kinship networks, and through their kin obligations expressed in remittances. The biomedical bodies of Salvadoran migrants emerge through interactions between people, objects, and technologies that manage to enact their medical problems.

1.1 Introduction

I arrive at remittance clinics by tracing the paths traveled by patients I meet in waiting rooms. In cities saturated with specialty clinics, patients come from neighboring towns; in small towns with one or two private primary care clinics, patients come from further away villages. After visiting several private clinics in small towns, I decide to live in one of the most remote towns in the high-remittance eastern part of the country. I call this small pueblo, El Ocotal. No place in El Salvador is really remote—the country is tiny and densely populated. Within its 21,041 square kilometers and its 6.4 million people (DIGESTYC 2014, 3), no place is more than a few hours away, even in the absence of well-maintained roads. Empty expanses of land cannot be seen even when traveling off-road. But "remote" is a relative term. I use it here to denote its distance from city centers, hospitals, and specialty clinics. As the administrative center of the larger territorial division of El Ocotal, this pueblo enjoys reliable electricity, a sewage system, trash collection, potable water a few hours per day, and a paved road that connects it to a highway. But according to the 2007 census, only ten percent of the population of El Ocotal lives in the town itself, the rest do so in the rural areas that make up the larger territorial division where these amenities are largely absent and the economic activity is family-based agriculture, artisanal cheese making, and remittances. Although the state denominates the town itself to be urban, I call El Ocotal and towns like it "rural towns" to denote their agricultural economies, the living condition of the people that come to the town, and the relative remoteness to access secondary and tertiary healthcare.

In El Ocotal, most families have relatives living in Long Island, New York. Although it sits at the top of a mountain in a region identified as one of the hardest hit by the civil war, locals say they only experienced sporadic artillery confrontations. Many people did leave at that time, through the eighties, but many more left in the subsequent years of the early nineties. Remittances started rolling in quickly after people started leaving. The days when locals sat in amazement watching the town change right before their eyes are gone, however. Remittance and migration are commonplace and no cause for amazement or complaint. The afternoons fill with tales of the drama of migration—separation, return,

and the eventual indifference of those who have left. During the remittance heydays in this town, one pharmacy turned into four, which in turn gave way to three private primary health clinics and two small laboratories that run basic tests.

Doctors have been increasingly coming 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, who have quite varied migration histories and statuses, call these new "town doctors" for all kinds of medical advice and orientation, many times seeking diagnosis and 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 almost no other technology except for the rare image shared over social media sites. For instance, Miriam (all names in field stories are pseudonyms), a woman who says suffers from "espolón en el talón" [heal spur] one day comes wobbling into the clinic not to see about her problem, but to see about her son's problem. She 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.

In this chapter I examine the human and non-human relations that remote diagnosis requires when done without advanced medical, communication, and information technologies. By asking how the medical body emerges, the chapter navigates the actor-networks that produce a medical body for the doctor to diagnose and treat with minimal medical and communication technologies. I highlight the relevance of remote diagnosis sans advanced technologies through a discussion of telemedicine as a project conceived in the US to extend access to the geographically remote, which renders El Ocotal as a "remote client" rather than the "center provider" that it is for Salvadoran migrants.

The possibility of diagnosis in a technology-limited space, without access to laboratory exams, medical imaging, or basic biometrics is only jarring in a medical world where primarily the biosciences produce knowledge of disease. It seems a clinic without a physical

body and without the science to make it into a medical body is only a conundrum when one takes for granted the body and its infinite biology as the most important object of knowledge in medicine. Diagnosing without a physical body and without a "zoomed-in body" via medical technology and information is surprising only if one presumes that bioscience is the basis of competent medical practice. I wonder what enables a medical world to diagnose without a physical and a techno-medical body. This chapter tries to describe ethnographically how the medical encounter looks like without the physical body and without the zooming into the body that becomes available through medical technological devices and practices. I explore the doctor-patient relationship in the clinic in a peculiar situation, one where the focus remains on the biomedical body but where the physical body and its medical information remain limited, if not completely absent. I ask, what kind of body emerges when its physical presence and its biomedical information is limited and what makes its diagnosis possible.

In the life I observe in El Ocotal, the conditions 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 seem 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. Inspired by the work of Mol (2002), where the different knowledge practices of the pathology lab, the ultrasound exam, and the clinical encounter enact multiple atherosclerosis diagnoses, I take a look at how the patient in the clinic is not singular either. When remote patients come into the clinic I observe in El Ocotal, they come through a dispersed set of relations that make their diagnosis possible.

The body dispersed is not only produced through local practices of interaction born

out of the need to communicate across distance. Local pharmaceutical consumption practices seem to lay some ground for how un/important the individual body is for diagnosis. Pharmaceuticals seem to have entered this area without the physical examination that characterizes biomedical clinical practice. Before the presence of any kind of state medical services in El Ocotal, there was one pharmacy, La Farmacia del Pueblo. It still exists in its original building, although it has changed owners. Niña Gloria, a registered nurse turned pharmacy owner who came to work at the public health post when only La Farmacia existed, remembers the owner fondly. He used to attend all kinds of emergencies and health problems—he sutured, set bones, gave shots, and recommended pharmaceuticals. In the seventies, when the state built a public health post in front of La Farmacia, he remained an important source of pharmaceuticals and health advice. Anne Ferguson (1981) in her research on the western part of the country about the distribution of prepackaged pharmaceutical products manufactured by multinationals, found intense distribution of pharmaceuticals through pharmacy clerks, shop owners, medicine vendors, and pharmaceutical company sales representatives, all of whom also functioned as primary sources of health advice and treatment. Interestingly, she observed that, "In none of the shops, however, did pharmacy personnel undertake physical examinations of patients" (122). I encounter similar distribution of pharmaceuticals and health advice in even more informal situations: in bus stations, inside buses, open air markets, or any busy place with people on-the-go. I collect a small assortment of pharmaceuticals offered through elaborate performances on bus rides. Medical anthropologist T.S. Harvey (2011) interprets similar performances and health narratives in Guatemala as alternative forms of distributing public health information. Where I travel, medical graphs and images, bio-scientific information, and well-rehearsed stories of illness and cure accompany the mobile theatrical performances. But examinations of the body are markedly absent. Diagnosis becomes a comparative and personal analysis of narrative of symptoms, and treatment the purchase of pharmaceuticals. I think this kind of medical interaction, where the object of medicine is the pharmaceutical and not the examined body, permeates the medical encounter inside the clinic and facilitates the treatment and diagnosis of bodies that are

not physically present. The intense availability of pharmaceuticals and their informal distribution helps maintain a practice of receiving and even requesting medical advice from vendors in circumstances in which the body is not medically examined in any way.

This is the context in which remote diagnosis of Salvadoran migrants takes place in the rural clinic. My approach to study the diagnosis of remote patients emerges in conversation with STS conceptualizations of "the body" in medical practices (e.g. Berg and Bowker 1997; Berg and Harterink 2004; Mol and Law 2004). In their interest to study the materiality of technoscientific practices, STS scholars have entered the laboratory as well as the clinic to ethnographically describe how bodies are *made* in practice. Following STS scholarship, these authors do not attempt to give a definite answer to what a body may be. Instead, by foregrounding action, they examine material practices and devices through which bodies are *done*, through which they come into being, into reality. Within this framework, medical bodies in the clinic are not defined by scientific discourse or by the subjectivity of patients, and do not preexist the practices that bring them into being. Instead, they are made through the actions and enactments of doctors, patients, technologies, devices, therapies, procedures, and so forth. Bodies "are not social constructions or texts; things, practices, architectures play a core role in their construction" (Berg and Akrich 2004, 4). Examined in this way, the body in clinical practice emerges as an entity always in the making, through multiple interventions and relations. STS scholarship has been rich on this issue. For example, Berg and Harterink (2004) examine how the clinical patient in early 20th-century US hospitals emerges through the patient-centered medical record. Turning to enactment rather than performance, Mol and Law (2004) investigate the ways bodies enact hypoglycaemia by measuring blood sugar levels with medical devices, by feeling shivers and sweating, by responding to metabolic changes after eating, by doing things to avoid a coma. These actions, Mol and Law suggest, also enact a non-coherent body, they bring into reality multiple hypoglycaemic bodies.

By now, STS has given several examples of how medical practices, material devices, and people create bodies that are neither whole, singular, nor individual. I draw from this literature to ask what kind of medical body emerges in clinical practice in El Ocotal,

where the usual material practices and devices that bring into being biomedical bodies in the STS literature remain limited. I pay close attention to the ways "bodies" (human, objects, technologies) are not singular, not through an extensive look at their practices, but through an examination of how bodies "become" one another. I look at how the bodies of remote patients must undergo a string of "substitutions" in order to become biomedical bodies ready for diagnosis and treatment. These substitutions "move" one body into another, they become "proxies" for the other. The mother is a proxy for the son in the clinic, the phone is a proxy for his voice, the kinship networks a proxy for his genes, remittances a proxy for his obligations. The body of the son in the clinic becomes a "stack" of multiple versions of his body in different forms, all unsteadily putting together, or as Mol would say "hanging together," his biomedical body. By using the term "proxy" I want to highlight the mediation in constructing medical bodies in the double "tele" conditions in the Salvadoran case, in which the usual medical technology that enacts and embodies patients at a distance is absent, and many other objects and persons with a *clear mark of being substitutes* come to manifest the Salvadoran migrant patient.

The term "proxy" also refers to a process. In my analysis, proxies make what they mediate; they do not merely bridge two pre-defined entities. In other words, I examine proxies—remittances, phones, mothers, patient narratives—as actors that make others act in such a way that the body of the Salvadoran migrant in the US comes to be a reality that "is diagnosed and treated." Others have used the notion of "embodiment" to note this process (e.g. Berg and Harterink 2004). But embodiment dims the mediating entities and highlights the actions of becoming. I want to highlight the mediating entities to stress the added difficulty in making not a digitized patient that travels, but multiple patients that make possible remote diagnosis. This form of proxy seems to be a form of material-semiotic translation, in which objects become other objects, where "translation is displacement of the object directly" (see Michel Serres in Brown and Capdevila 1999, 35). The kind of "translation by proxy" I see in the ethnographic material I analyze in this section is not the translation of interests that makes actor-networks (Callon and Latour 1981; Latour 1987), but the enactments of objects that makes them such. In chapter 4, I

examine the failure of translation of interests that results in limited remittance networks, but here I look at translation as a form of one thing "becoming" another.

1.2 Everyday Proxies

El Ocotal is the last town in the northeastern corner of El Salvador—the paved road ends there. The villages scattered through a hilly and difficult geography connect to the town via unkempt dirt roads. The geography of the area makes certain areas inaccessible during the winter. The rough mountainous geography of the northeast region has a lot to do with the reduced mobility of villagers, and the lack of good roads, safe and affordable transportation, and the different waves of violence (civil war before, narco-trafficking now), all compound the inconvenience of travel. Although kilometer-wise quite close to towns and cities, these villages seem far away given their transportation inaccessibility. The asphalted road connecting El Ocotal to a primary highway crossing the country came in small increments during multiple decades, the last section completed in 2009. But by the time the last section was finally paved, middle sections were already in total disrepair, making travel on broken asphalt more difficult than it was before pavement. In 2012 the Millennium Challenge Corporation with the Salvadoran government, finished a highway meant to improve access to the towns that connect to El Ocotal,[1] and the national government repaired sections of the deteriorated road. 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 busses run from the hilly villages, passing through El Ocotal and neighboring towns to Santa Rosa de Lima, a market hub supplying the eastern region with imported goods, especially apparel and pharmaceuticals. Although the distance between El Ocotal and Santa Rosa is only 34 kilometers, the trip lasts two and a half arduous hours at the beginning of my fieldwork. By the time I leave, the construction is complete and the trip lasts half that time. The small dirt roads that connect to small villages remain in bad shape, especially during the winter, when rivers

1. The Millennium Challenge Corporation, a US foreign aid agency, convened with the Salvadoran government a $461 million grant to "Increase human and physical capital of residents of the Northern Zone to take advantage of employment and business opportunities" (MCC 2006), which funded the construction of a high-speed highway.

and creeks swell and it's impossible to cross without a double traction vehicle.

The buses that serve the area are in poor condition and only make two trips per day. The state regulates the fares, but safety, schedules, and routes seem to concern no one. Returnees from the US and their male relatives often run small pickup trucks shuffling small groups of people from further away villages to El Ocotal. People complain about the unpredictable high prices for this kind of informal and illegal transport, but without alternatives, children and old people hike up truck beds and brace for the unsafe jumpy, dusty and, at times, muddy ride. These drivers and their passengers, constantly deliver messages sent by their neighbors or friends to people in the town. They are always fetching information, delivering goods, representing friends, and saying what others tell them to say—they are constantly standing-in for others.

Despite the presence of a public health clinic recently relocated to the edge of town with improved facilities and increased staff, and the presence of three private clinics, pharmacies are often the first place where people seek advice. Niña Gloria, 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 pharmaceutical products: injectable analgesics, vitamins, and birth control drugs, tonics, and antibiotics. In the villages of El Ocotal people constantly send messengers into town or further 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 not the exception. People come to the pharmacy to ask for medicine for a friend, a neighbor, a relative that is too sick to move, or one that is too busy to come. They narrate a list of symptoms and possible causes to the pharmacist, and ask for medicine to get better. Niña Gloria prescribes. School children, who are already coming into town for school, are many times these medical-information messengers—they come with wrappings or packaging containing drug information, a piece of paper with the name of a product, or a memorized message: *my mom says she needs something for my little brother's fever*. Sometimes Niña Gloria does not have that particular brand and offers something sim-

ilar, but the children, instructed to only get what matches the wrapper, leave without negotiating. In general, people acting for others deliver a request, a message, they speak someone else's words. For people from El Ocotal to seek health advice for a relative living in the US is not any different than to do it for a relative that is back in the village.

People come to El Ocotal to buy someone else's toiletries, pay someone else's bill, pick up someone else's remedy, or state someone else's symptoms. One of the hardest things to do is to get someone else's remittance, but it is not unheard of for someone to convince the teller to issue a relative's remittance with proper ID, especially if the teller knows both people. People come to town to run their own errands, and fulfill *encargos* (other people's errands). The commonplace of *encargos*—literally to put someone else *en cargo* (in charge)—highlights the constant standing-in for others in everyday activities, daily errands and tasks. Children speaking for their parents, adults representing their relatives at banks, or neighbors stating friends' symptoms are some of the body dispersals making possible not-physically-present bodies to do things every day.

Niña Gloria's pharmacy space is also a proxy of sorts. *Encomiendas* (care packages) coming from the US arrive to the care of Niña Gloria, who personally delivers them or arranges for pick-up. The place itself *acts* as a convenience store, a post office, a bus station, a storage facility, and even a micro-credit lending office. Those who need rides going north wait on the pharmacy's porch until there is enough people for a full ride. I sit on the bench inside, next to the merchandise being delivered that day, and the packages stored by villagers while they run one last errand. In saying the pharmacy "acts as," it "plays the role of" a bus station, a storage locker, a convenience store, or a micro-credit lending office, I follow an STS intellectual trajectory that investigates the identity of objects as if they were on stage. If objects, like subjects, as STS scholars suggest, "have no fixed and given identities, but gradually come into being" (Mol 2002, 42), then Mol's suggestion to examine how an object *enacts* its own identity, seems particularly useful. It may seem trivial to think about pharmacies and bus stops through the intellectual work that breached the dividing line between human subjects and natural objects and staged the natural sciences as reality enacted, as opposed as permanent always already there.

The pharmacy has never suffered from the sense of universal reality that overburdens nature; the social sciences have made common sense to assume pharmacies and bus station are made in society and thus are historically situated. Nevertheless, I find useful to think about how the pharmacy enacts a bus station through the everyday practices, in order to stage the problem of how absent objects must come into being, how objects must do the work of other objects. That the pharmacy enacts the bus station becomes interesting in this case, to me at least, because the bus station is absent. It is this work to make something absent appear that I try to capture with the term "proxy." Instead of highlighting the practices that make the pharmacy a pharmacy, I want to highlight the work of substitution the pharmacy does in enacting the bus station. The pharmacy is standing-in for the bus station. There is a "doubling" the term proxy carries—the pharmacy is not only a pharmacy, the pharmacy is also a bus station. It seems in El Ocotal everything and everyone is a proxy for other people and other things. Nothing is only itself.

1.3 Patient Proxies

I spend most of my time in El Ocotal at Niña Gloria's pharmacy and Doctor Cardona's clinic. He established his clinic in 2004 and later his wife opened a lab in the same rented house, which Niña Gloria owns. The Cardonas work as a team, on Thursdays and Fridays they schedule the older patients needing blood work and on Tuesdays and Wednesdays everyone else. On Fridays it's impossible to find a chair—the waiting room is filled with older people exhausted by long trips endured on empty stomachs. Every day there is at least one person who is waiting to see the doctor in place of a relative living in the US. Like Miriam, the mother quoted in the introduction of this chapter, mothers and wives come to the clinic with their mobile phones tucked in their 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 and hands the phone

over to the doctor. Doctor Boris, in a nearby town, says many people in the US have his number—after a mother or wife makes the initial connection and he prescribes treatment, he asks relatives to contact him directly for questions or further consultation.

Telephone medical consultations happen quite often in this area. All the doctors in the eastern part of the country I speak with, tell me they diagnose and treat migrants over the phone with some regularity. Many people and material objects have to stand-in for the absent migrant in order for the diagnosis to be possible—the phone as the only communication device is not enough, an oral history of the disease as narrated by the patient is not enough.

Messengers

The physically present person at the clinic speaks for, or sits in place of their relative in the US. They represent, as in "speak for," and re-present, as in "making present again."[2] When asked what brings them to the clinic today, they answer, "vengo en lugar de" [I come in place of], or they are "pasando consulta por" [consulting for] their relative. I find their words quite compelling. They emphasize making their relative 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. In the moment Miriam is acting for her son, she is him. Before the doctor asks to speak to the son directly, he asks her what else does he feel, what has he taken, and only after she has relayed certain information does he ask to speak to him. Not only does she take the place of his body in the waiting room, but she also speaks his symptoms, medical history, and migration story. When the doctor asks "¿y qué más?" [what else?], she conjures his sickness. She becomes him in the briefest of moments, then she quickly steps out of his body and dials to establish communication between the doctor and the son.

2. See Spivak (1999, 156–164) for an interesting discussion of the political and philosophical differences between represent and re-present; my analysis, however, is less about the differences between the terms, and more about effects and linkages between both actions.

Kinship Groups

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: in repetition, a form of kinship statistics, and in the "family predisposition" of kinship groups. Kinship groups become proxies for the conditions that "run in the family." The medical bodies and health problem 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 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.

In his computer, sitting to the left of his desk, Doctor Cardona creates a record of the absent patient as he would if the patient was present. He records what the mother tells him, plus what he is able to get when speaking to the remote patient. When he gets a consultation call outside of his clinic, he says he jots down pertinent medical information on any piece of paper and later enters it into his computer system. Doctor Boris, in another small town, shows me a blank form he uses to record the medical records of his patients. The form contains spaces for the first and last name, age, weight and other biometrics, and a schematic of a human body. He uses the same form for patients calling from abroad, and stores it along with the rest—inside manila folders with the last and first name handwritten on the tab. His secretary mentions last names repeat often, making

large groups evident on the shelves holding patient records. It seems records are not individual records, they contain information given by those relaying information, and sit "in company" of relative's records on the shelf, or inside the computer database. There, patient records contribute to patterns helping diagnose remote patients.

Migrant Stories

When I ask doctors about the most frequent pathologies of their remote patients, they come up with a different repertoire than the ones mentioned for their local patients. Even though the body of the one afar is substituted with the knowledge acquired from the local body, the diagnosis is different. Bodies of migrants often suffer from diseases related to their new work environments: allergies and skin diseases for those working in landscaping, stress for those working in kitchens and those recent arrivals, for instance. The bodies of the distant patients emerge in narratives of migration, as they appear in mainstream media and family anecdotes. Doctors want to get the story of how their patients migrated, whether they have found work, left children or spouses behind, spent a long time en route, or arrived to a fraught environment.

According to doctors I interview, many of their remote patients have some kind of relationship with healthcare in the US. Some emigrated long ago, have stable jobs, are documented and have health insurance through their work, others are recent emigrants without documents or health insurance but pay out of pocket for medical services. Many have recently used health services where they live, but give little information about what happened in that medical encounter. Doctor Cardona tries to get as much medical information about diagnosis, exams, prescriptions, or types of consultations they may have recently had. But this is difficult. Doctor Boris, who conducts some consultations over Skype, asks for patients to show him drug labels to get information about what they are taking. They express they know very little about the medical histories of their remote patients. But stories of migration, work, family obligations, and feelings come easily, and so, they try to piece together medical histories out of life stories.

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 with 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. She works long hours, is exhausted, in physical pain, and cries all the time. Niña Gloria only eventually asks about her symptoms. She later tells me, 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 are willing to pay, what they hope for. Niña Gloria sends her vitamin B-12 and Diclofenac (an analgesic) in injectable form, along with more vitamins in several packages—a remedy common for *nervios*, a condition common among women in stressful situations. 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.

Viajeros

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. Relatives ask about what may escape photographs, letters, or calls; they want to know how do 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.

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

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.

Phones

The doctor takes the phone and attentively listens to the list of symptoms, takes notes, asks questions about other symptoms, diseases, allergies, family history, height, weight, age, etc. They chat about family affairs, work, and life. Finally, he writes a prescription and hands it to the mother, who will send it with a relative or a *viajero*. The phone, the most obvious proxy for the patient, relays his narrative of symptoms, which include a narrative of his current family affairs. With it, the doctor builds his medical case. The phone works as medical technology when it's relaying the voice of the patient and his symptoms. But the phone is not only a medical or telecommunication technology, it also plays the role of the patient, especially in the hands of the mother. In her pocket the phone holds her son.

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The absent patient emerges only through its association with persons and things. The phone is not sufficient to become a remote patient—it needs the mother that holds the phone, 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, social conditions of disease.

But the consultation itself is not only a medical consultation. The medical consultation does not start when the mother hands over the phone to the doctor, or when the mother enters the clinic. It starts in the intimacy of family relations, in the middle of family affairs. The medical consultation itself is a proxy for family relations. It enacts a family-making

process. When the mother goes into the clinic with the phone tucked inside her apron pocket, she is doing something with/for the son, she is "becoming" with him. For families separated by migration being able to attend to the illness of a relative is an occasion for becoming present in each other's lives. The medical body of remote Salvadoran migrants are enacted through family affairs, and in that entanglement diagnosis does not depend only on the individual biological body and its medical enactments, but also on intimate family relations. The diagnosis in this scenario is not only a medical process, it's also a familial one.

1.4 Ties

The relatives of Salvadoran migrants coming to the clinic requesting an over-the-phone consultation are most of the time patients Doctor Cardona sees on a regular basis, with whom he has a close rapport. Even though he feels uneasy about the call, he says he cannot say no. When I ask him why, he says he feels he needs to help them, they have no one else to turn to, but ends with a reflection about how his patients would not forgive him and would not come back—they would take it as a denial of service and a betrayal. It seems doctors do it reluctantly, acquiescing to the request of local patients who will not return if they decline to provide care to their relatives. Doctor Cardona's patients expect him to take the call, providing advice is an expected obligation in order to maintain relationships with his patients.

Doctor Cardona's obligation to his patients articulated through remittances may indicate a form of social reorganization of indebtedness taking place in towns like El Ocotal. To one side of Doctor Cardona's desk, sometimes I see the small blocks of cheese or bags of eggs his patients bring, expressions of "eternal" debts to the healing hands of doctors. These debts seem to produce similar social arrangements as the gifts well-to-do families give at commemorative events, through which they earn the indebtedness and loyalty of those who cannot repay in kind. A man tells me after gifting large amounts of foods at a church event, "Ahora ya podemos andar tranquilos" [Now we can go around peacefully]. The debt that cannot be repaid by less powerful townspeople translates into protection

for those who do the gifting. Debt works as a form of social organization, as the theory of gift exchange explains. But remittances are a new card on the table. They engender different kinds of relationships as they shift who is indebted to whom. The doctor is now in obligation to the patient, a debt that seems he can never repay and instead expands as more remittance patients bring their relatives in their pockets. Doctors take the calls to satisfy a seemingly "eternal" debt.

Remittances bring new forms of obligations, but also are the manifestation of old ones. Remittances can be converted into medical consultations, pharmaceuticals, hospital stays, medical tests, and as such, can stand-in for care and nurture. Their exchange into health services materializes family obligations in the form of care for relatives. In this way, remote diagnoses of relatives form part of family caring practices. The son sends remittances which turn into health for the mother, the mother takes the son in her pocket to care for him. In this scenario, more family care and nurture may mean more medical consultations and pharmaceuticals. Some of the patients I interview with their relatives in their pockets say their relatives abroad did visit the doctor in the US, but were only prescribed "pastillitas" [little pills] or nothing at all. They have come to the doctor to see about sending them proper treatments, not diminutive ones. They prefer, in the words of a doctor, "aggressive treatments" involving injections and several pharmaceuticals. "More medicine" forms part of the medical practices of remittance clinics, where remittances manifest the nurture and care for relatives.

Doctor Cardona also sends treatment packages he prepares himself. Usually he gives prescriptions and recommendations directly to relatives, who buy the therapy at a local pharmacy and send it via courier or with a traveling relative or friend. In one instance he was asked to send treatment to a patient he had previously treated in his clinic in El Ocotal. The young man suffers from knee pain as a result of an old sports injury. When he came to Doctor Cardona's office in one of his trips, the doctor gave him a corticosteroid injection in the joint, but this time the man had sent his mother to fetch the medicine. Doctor Cardona told the mother he would bring the medicine tomorrow because no one would be able to fill her prescription in El Ocotal. The next day he came with a package

and a prescription sheet with drawings and careful instructions on how to give the shot in the joint. He explains he hopes the patient gets a professional to administer the shot, but in a pinch, he may need the instructions to guide him or someone else to do it. In the instructions the doctor included his phone number and a request to please call him when he gets the package. Patients act as their own nurses in these transnational medical relations. One of Doctor Cardona's patient even learned how to purchase, use, and read special strips to measure his liver function, others have learned how to take their own blood pressure and interpret the results. These prescriptions create intimate ties between Doctor Cardona and his patients. The medical information contained in them and the accompanying drugs, are not easily available to patients calling. The connection to Doctor Cardona comes through family relations and obligations, and as such is not found in the "yellow pages" either in El Salvador or the US. The obligations doctors have with their patients, those patients have with their doctors, and those relatives have with each other, make possible the actions and interactions that enact the Salvadoran absent patient inside remittance clinics.

1.5 Telemedicine Otherwise

With the relatively recent global possibility of remote access to extensive and complex medical information and visualization, a variety of medical subspecialties have developed strategies to connect with patients across distance and time. Telemedicine has come to fill the hopes of a wide range of interests. Managers of healthcare in the US and Europe have promoted telemedicine as a solution to increase access, decrease cost, and shorten long wait times (Mort et al. 2003), while physicians in India who connect with their counterparts in Africa see it as a possibility to transfer expert knowledge (Duclos 2015). Sociologists and anthropologists of science have studied, for instance, the use of videoconferencing within psychiatry (May et al. 2001), videoconferencing with parallel transmission of vital signs and other clinical data in internal medicine (May and Ellis 2001), store-and-forward digital imaging systems in diagnosis in dermatology (Mort et al. 2003), technical devices to support chronically ill people in home care (Pols 2012), and

teleconsultations between Indian and African physicians in hospital settings (Duclos 2015). Some of the studies of telemedicine published in the first decades of the new millennium mark a shift in the focus of telemedicine, from being about the use of teleconferencing to primarily diagnose, to being about how multiple devices and technologies can nurture, support, monitor, and care for patients. As information and communication technologies enter the home and the personal lives of patients, and become ever more present in the production and management of medical data, telemedicine enables new arrangements in a wide variety of settings, such as "clinical decision support, prescription ordering, disease management, patient empowerment, and disaster preparedness response" (Bashshur 2009, 5). From international health organizations like the WHO, to medical anthropologists and sociologists, now instead employ the term "eHealth" to capture the diverse array of applications of information and communication technologies in medicine that go beyond making remote diagnosis a priority.

Some scholars have noted the "dispersed" sense telemedicine carries in its focus to connect at a distance. On a recent "think piece" published in the online journal *Medicine Anthropology Theory*, Vincent Duclos (2015) reflects on the "dispersed, emergent medical gaze" in teleconsultations between Indian specialists and their African colleagues. He states,

> In contrast with the practices of seeing, hearing, and touching bodies that characterize the modern clinic (and bedside care), teleconsultations take as objects bodies that are screened, digitized, and transmitted over the network.. . . This is a dispersed, emergent medical gaze, with its own 'sensorial economy', or distribution of the visible and the invisible. (157).

"Dispersed" may be the image many of us want to evoke when writing and thinking about how medical bodies in teleconsultations come about. Although the over-the-phone consultations occurring in El Salvador differ significantly from the ones Duclos describes, we share a sense of dispersal to describe the multiple and spread locations and objects making possible clinical encounters at a distance. But the examination of "screened and digitized" bodies forms part of a long tradition in biomedicine; I'm not sure its dispersal is "emergent." Before patient charts, x-rays, scans, and medical data were sent over the

wire, they had already been circulating through hospital rooms and offices. In fact, Paul Atkinson writing on the contemporary clinic noted,

> the clinical gaze is no longer anchored to the bedside itself. The clinic's gaze is now dispersed. ... The body is sampled, invaded and inspected in order to yield images and information. Those data can then be scrutinized and interrogated elsewhere—in the specialist departments and laboratories of the modern hospital. (quoted in Mort et al. 2003, 276).

That the inscriptions of the body in data are not anchored to the "bedside itself" and that they circulate detached from the body is not something that emerges with the rise of telemedicine. In the US the emergence of the circulation of the body-in-data comes with the introduction of the medical record in clinical practice (Berg and Harterink 2004). But I think the clinical gaze that emerges with biomedicine even before the introduction of the medical record, the one attached to the bedside itself, was in a sense also "dispersed"—it attempted to abstract information from the empirical body through medical training. When the "touch" of the body becomes a diagnostic device—when "seeing" and "reading" bring into reality medical problems—it becomes "dispersed touch" so-to-speak. The gaze is attached to the doctor and his medical training, not the patient, and in this way it circulates. But how touch or technology produces medical information is a matter situated in the very diagnostic device, and as such, emerges anew at each location.

What seems emergent then, are the dispersed locations and processes that produce and use the traveling data. The enactment of medical bodies occurs through material devices and practices located not only within different knowledge practices in a hospital (Mol 2002), but within different geographic locations and even time spans. In an ethnographic analysis of a teledermatology clinic in the UK, Mort et al. (2003) find the digitization of the body and its evaluation steps outside the hospital and into the community it serves, which shows how "the practice of telemedicine delocalizes the technologies of 'inspection and enumeration' ... and permits their territorial expansion" (276). Instead of "dispersal" of the clinical gaze, the authors talk about a "fragmentation of clinical practices," by which they mean, "Diagnosis has become detached from the traditional configurations of medical practice: it is separated from the production of a medical history and separated

from the clinical management of patients" (Mort et al. 2003, 278). This fragmentation, they argue, is unlikely to contribute to positive patient outcomes since it contributes to a loss of knowledge of the patient's psychosocial states, anxieties, worries, fears, family circumstances, and so forth. Others in close academic fields such as philosophy have also cautioned against the proliferation of telemedicine. Keith Bauer (2004) finds cybermedicine threatens the moral integrity of the doctor-patient encounter because it "retards physician compassion and patient trust," as physicians have "lost the knowledge" of important patient circumstances that cannot be inscribed on the data, images, or charts.

The "body dispersed" that emerges in El Ocotal echoes the distributed geographies and fragmented practices of diagnosis others have pointed out in their analysis of telemedicine. But I have used the term "dispersed" specifically to highlight the distribution of actions that enact bodies through many material devices and practices. What I have wanted to point out is not only the different locations of those producing and reading medical data, but 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 how there is no single patient to speak of. When a patient comes into the clinic of 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 remote patients 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 family and obligation "technologies." But this "dispersal" would not have been possible without the historical development of

the embodiment of the medical body in data, images, and visualization practices. The medical body of Salvadoran migrants is put together through intimate patient-doctor engagements, entangled in obligations and trust. In the Salvadoran case, physicians take the call out of compassion and obligation not only with the caller, but with their extended kin. The physician in rural clinics does not seem to have a loss of knowledge of the psychosocial states, anxieties, worries and fears. Perhaps, instead, he has "too much" of this kind of knowledge and not enough of the digital kind. What counts as care may be a worthwhile question to ask in future analysis.

1.6 Conclusion

Doctors in El Ocotal build thick relationships with their patients, often the consultations last hours and involve conversations about the patient's land and animals, legal and money problems, and family relations. Doctor Cardona between laughs tells me that sometimes they just need a listening ear, and he is happy to be that ear for them. Sometimes when he is ready to leave, he sees at the door one of his elderly patients that loves to chat, and he says "oh no, I'm going to be late picking up my kids," and sits downs for a long conversation. At another clinic, patients tell me that they come and pay for private care because here they are touched, they are called by their names and they are never looked down upon. Ironically, it is this very quality of the doctor-patient encounter that is desired and yet transformed in these medical phone consultations. Touch takes other shapes—it becomes evident through *viajeros*, care packages, accepted calls, and so forth. Care is not only about one person, it is held in a network of heterogeneous relations. In these phone calls, care, pharmaceuticals, and treatment practices travel, move from one place to the other, but doctors and patients stay put and at a distance. Relations, repetition, similarity, and statistics make the medical body able to manifest itself for treatment elsewhere.

Chapter 2

Becoming Present

Abstract. Patients in remittance clinics in rural El Salvador make many demands—they ask for thorough physical examinations, they request prescriptions, they demand to be admitted to hospitals. Doctors complain and feel uneasy about these demands, but they also acquiesce. I frame these requests as crucial actions enabling relations through which the patient emerges as a relative, a patient, a social being. This chapter explores clinical interactions in the context of the need to assert relations when those relations are precarious and their future is uncertain. I argue that remittance-receiving patients in El Salvador use the urgency of the medical space to make themselves present in the lives of their relatives in the US, and in doing so, transform medical practices and force their attending physicians into ethical dilemmas. The urgency of the medical space is sought to act as a "border regime" (Lindemann 2007), to prove "life" through an "emergency" that demands an immediate response in the face of death. Relatives in the US are asked to reckon with the "almost-dead" in El Salvador, and their response brings them into being as "relatives." Their re-action enacts their family relation.

2.1 Introduction

In chapter 1, The Body Dispersed, I discuss the problem of enacting biomedical bodies of absent patients through family relations and their intimate medical encounters, rather than the usual inscription of bodies through medical technologies able to travel. Drawing from conceptualizations of "the body" in science and technology studies, and local rural

practices of mediating distance, I suggest the medical bodies of Salvadorans living in the US manifest themselves in a dispersed way—through their mothers, through the biomedical materiality of kin, through migration stories, and through obligations materialized in remittances. The physically absent patient becomes present through a network of people and things. I explore another aspect of the process of enacting medical bodies in this chapter. While physically absent Salvadorans living and working in the US become present in the clinic through dispersed heterogeneous bodies, their physically present relatives use medical spaces to also insist on their own presence. This chapter explores the ways rural Salvadorans with relatives in the US use the urgency of the medical space to sustain their presence in the lives of those who left, and also, importantly, to reaffirm their own being in their local lived social space.

This problem of *needing* to negotiate presence is not something that afflicts us all. I believe it is particular to migration, to the impossibility of reunification given legal and economic barriers, and to the loneliness that is increasingly more biting as relatives age. This kind of physical separation is the particular condition that informs the desire to be present in this chapter. Even though the lack of physical presence, as it weighs heavy on the bodies of older relatives, is a major concern, I start with the understanding that physical presence does not automatically make people present in the lives of their relatives. Loneliness can be deeply felt while in the company of others. Presence is thus much more than physical presence. Relatives are not present in each other's lives just because they live together and see each other every day; presence must be practiced, it needs to constantly be done. This chapter grapples with how relatives in El Salvador do this; it focuses on the practices of relatives to become present, to *be* in the lives of others.

The field of transnational migration studies has contributed important research on the ways transnational families forge intimate connections across distance in the short and long term. For example, with the rise and increasing affordability of information and communication technologies in the first decades of the new millennium, migrants have been able to transmit their own stories, images, and experiences to more intimately connect with their families (Benítez 2011), and migrant parents have been able to participate in

the lives of their children, intervening in daily decisions concerning their rearing (Mahler 2001; Parreñas 2005). I focus on the medical space as a peculiar and less evident space used in the practice of becoming present in the lives of relatives. Much of transnational migration studies has focused on how information and communication technologies in our contemporary globalized world have transformed the ways in which families stay in touch and participate in the daily lives of each other in meaningful and intense ways. Migrant demands for staying in touch have also affected the ways communication technologies have spread through wide infrastructure networks, have been marketed to remittance receiving populations, and have penetrated the intimacy of households split by distance. Cell phones are used in previously unimagined ways; the occasional landline expensive call to celebrate birthdays and communicate important life events has given way to daily calls to do homework with children, to text messages narrating the course of a day, to pictures showing the banality of day-to-day life, and even to daily pictures and texts reporting suspected cheating spouses by watchful neighbors. I would like to think presence beyond communication technologies—beyond the transport from one place to another of the content of quotidian life, of culture, things, and money.

To "become present" in other people's lives is an exercise in making them act, making them do things, making them do things for/with you. This is my launching point to think presence. When I say that presence is practiced, is done, I mean to say that presence occurs when there is a re-action, one in which the person becoming present needs to be reckoned with, to be unable to be dismissed or ignored. To become present is more than to be acknowledged or recognized, because it requires more than to be seen, read, interpreted or apprehended in desired ways. Presence demands action, it elicits a response. To think of presence in this way I draw from scholars that have helped me understand that physical presence of people is not self-evident, in fact that physical materiality in and of itself is not self-evident (Bennett 2010; Coole and Frost 2010). The presence of physical materiality is not enough to make something present, it must go through a process of becoming present, a process which is not about what the thing symbolizes and the decoding that must accompany it, but rather about how the thing is measured, manipulated, used, and

acted upon. What it makes others do. In and of themselves the pictures and texts sent over cellphones do not make those pictured present in the lives of those seeing the picture. Pictures need to act, and make others act, in order to make those pictured present in the lives of those seeing the pictures.

Medical anthropology scholars that study the medical body have contributed in particular to how material bodies become medical bodies through medical practices (Berg and Mol 1998; Mol 2002; Mol and Law 2004; Lock 1997; Scheper-Hughes and Lock 1987). A body in pain, or an injured body is not automatically a patient ready for treatment. The medical body is not self-evident, it needs to become a medical body. All bodies, those physically present and those who are not, need to go through the process of becoming medical bodies, a process in which "the single human being that forms the heart of humanism gives way to a composite picture involving many measurements, numbers, intuitions, habits, humans—not to mention dead ends and (often unresolvable) contradictions" (Mol and Berg 1998, 476). The particularity of the absence created by migration then is not the lack of physical presence per se, but the conditions of that absence in their efforts to become present.

Physical presence is not necessary for a patient to be diagnosed and treated at the clinic—and neither is it sufficient. Presence is enacted through a network of people and things—rural subjectivity is dispersed, acted through a series of relatives, friends, and neighbors, through obligations between doctor and patient. This is true for patients that are not physically there, as well as for those that are. This chapter is not an exercise in the metaphysics of bodies that have or do not have physical presence; it simply is an exploration of how remittance recipients in rural El Salvador use the medical space to make their far away relatives interact with them, and assert their relations that constitute their social beings. I'm intrigued by the ways medical spaces become a space sought to reaffirm a person's relations and their being. I explore how the medical space is used, manipulated, and transformed by remittance recipients as a space for negotiating presence with their relatives in the US and presence in the social space they inhabit.

My inquiry is guided by the surprise of how medicine is interpellated by migrants, and

how doctors and relatives respond to this interpellation. In trying to understand why medicine is sought in this way, I ask what does medicine do? What is it asked to do? I argue that medicine has the singular capacity as an expert knowledge to be a "border regime" (Lindemann 2007) between life and death, and as such it is uniquely capable to elicit an urgent dramatic response. Even though this chapter explores the ways in which medicine is mobilized by patients, I do not position patients in terms of personal agency. Medicine has traditionally been theorized as an institution that depersonalizes and deeply shapes the lives of individuals; in its origins the body is the object and target of power (Foucault [1975] 1995), and even when patients can maintain their agency, the empiricist power of the medical sciences silences the social person by making only the medical body speak. In medical anthropology the issue of patient agency has been a concern since its first writings critiquing the universalizing biomedical knowledge that silences and dismembers social persons. But more recent literature on the subject explores individual patient agency as neither the solution to a more humane and socially responsible medicine (Mol 2008), nor as completely absent even in highly technologized and bureaucratized medical regimes (Cussins 1998). A strand of science studies has investigated the ways non-experts participate in the making of science; for instance, patient groups intervened in shaping medical protocols during the height of the AIDS epidemic (Epstein 1996). What I want to explore here is a bit different, it's not about individual personal agency. I'm concerned with how medicine is called to perform an effect, an effect particular to medicine. Medicine is theorized here as a crucial actor that is able to demand actions from others, and as such it is sought.

2.2 Extending Consultations

During my fieldwork in El Ocotal, a small town on the eastern part of El Salvador, known for its high-remittance, high-migration demographics, I spend most of my time doing participant observation, and conducting informal and formal interviews in one of the four pharmacies, and one of the three private primary care clinics in town. After a few weeks interviewing patients at Doctor Cardona's clinic in the morning, and then spending the

afternoons sitting on a bench at Niña Gloria's pharmacy, I go to the public health clinic to meet with doctors and patients. The newly built public health clinic is inconveniently located outside of town and far away from the main road. I get there by foot during the noon sun, sweating, dusty, and considering the impossibility of those steps while sick. I arrive during the lunch break to find the clinic almost empty, but join a few patients siting on neatly organized chairs holding numbers on plastic cards. That day and during the following weeks, I interview patients and doctors in this public health clinic, and eventually speak with the director. She suggests I join the mobile unit making home visits far into the hills to see what medicine really looks like in the rural areas.

One early morning I join the mobile group of physicians and nurses in the public health system making their monthly visit to a temporary health post in a faraway village. While waiting for the patients to arrive at the post, the doctors make visits to nearby houses. In the first house a girl sweeps the cement floor and a very old woman swings in a hammock inside a dark room. The physiotherapist, an earnest young woman, helps her out of her hammock into a chair in the patio, where the nurse takes her vital signs and asks her if she is taking any medicine. Upon the long silence from the old woman, the nurse looks to the young girl for information. No one else lives in the house, just the two of them. The old woman's sons and daughters live in the US and she has not been eating recently, some neighbors check on them, the girl makes food and goes to school. The physiotherapist helps the woman to her feet and speaks near her ear, "You need to eat." "Ha?" "You need to eat." "Yes, I eat." "You need to exercise." "Ha?" "You need to exercise." "Ah." The conversation continues in spurts of loud questions and inaudible monosyllabic answers. The physiotherapist, worried, sad, and with a sense of defeat, returns the woman to her hammock. She finds me by the plastic water jars and softly says the woman is depressed, like so many other older people in town who are aging alone, without support, forgotten.

Small villages like this one have become the proverbial "ghost towns" inhabited mostly by older adults and school-age children (see Coutin 2007, 123). There are many households like this one in El Ocotal as well, older adults living by themselves, or with their grandchildren who await to join their parents in the US. Many of these older adults are

the patients that fill the appointment books of private clinics in the region. Doctors in the area tell me that they are aging without support, and usually this is the clientele that visits them in their private clinics. At the private clinic of Doctor Cardona in El Ocotal, Thursdays and Fridays are the busiest days. Early in the morning the clinic fills with older adults already diagnosed with diabetes or hypertension, coming for check-ups that include the obligatory fasting blood work. After taking a variety of transport, including the ubiquitous ride in the back of pickup trucks, patients arrive exhausted and are usually annoyed at the long wait to see the doctor, impatient to leave and finally break their fast. The vast majority are women, usually coming in pairs, some accompanied by neighbors or children. Although the waiting room feels crowded, there are only six or eight patients not including their companions, but each consultation lasts quite a bit of time, so the wait becomes painful. Doctor Cardona tells me he spends a long time seeing each patient; these women come not only to check on their hypertension, but also to chat, to tell him about their lives, to get legal advice or share the success and tragedies of their relatives in the US.

With a sense of pride in the work doctors do in rural towns, Doctor Cardona tells me his colleagues joke about their own predicament by saying rural doctors have their own specialty, they are "todologos" [everythingologists]. In addition to being general physicians dealing with all kinds of illnesses in all parts of the body, patients ask them for advice on life issues regarding land disputes, migration problems and even loneliness. He tells me certain patients come every month specially to chat with him, and laughs at his own situation noting these consultations could last more than an hour. Other doctors in private clinics in the area share this sentiment. Patients come to tell their stories and receive advice—their physical pain, discomfort, or maladies are told alongside the pressing concerns of their everyday life. In saying that town doctors are "todologos," Doctor Cardona acknowledges what doctors are made to be in rural towns. Doctors are asked to perform their expected role, which includes in this case the role of listener, paralegal, life advisor. Doctors become doctors by listening to the symptoms alongside complaints about land disputes and migration woes. Medicine as a space limited to lab

exams and prescriptions, gives way to medicine as a space extended to the condition of remittances intertwined with lab exams and prescriptions. The women that come to chat with Doctor Cardona blur the compartmentalization of life brought on by modernity, they obfuscate the edges between health and land tenure, health and family relations, health and financial uncertainty. For them, the clinic treats problems beyond the skin, or perhaps more accurately, it treats dysfunctions not bound by the skin. Under the "todologo" specialty, physiological symptoms of high blood pressure or knee pain in wet days, are not narrated separately from anguish of financial peril or the uncertainty of never seeing a son again. This blurring of borders could be misconstrued as a "return" to the whole body at the heart of humanism, the ideal "patient as a whole" erected as a normative standard (Mol and Berg 1998, 466). However, I think that as medicine is mobilized to perform multiple roles it proliferates. The patient also proliferates as it is not only the body of an elderly woman that comes for treatment, but also the body in connection to an explosion of relations. The narrative of symptoms extends beyond the physiological, and in this sense proliferates rather than unifies the body.

Aging remittance recipients ask medicine to do a little bit of everything, and quite surprisingly, doctors acquiesce. Doctor Cardona tells the "todologo" joke as a complaint, but he is seemingly quite proud he can do a little bit of everything. He can deliver a baby in breech position in the back of a pickup truck, diagnose non-classic presentation of appendicitis without scans, treat depression, and give advice on land tenure. He has been a migrant himself—he overstayed his tourist visa a while back and worked as a roofer in California. He came back to El Salvador because he loves being a doctor. He is a companion of the migrant community, and performs his role as a doctor understanding the inability to recognize where the border of health might be in relation to "everything else," an ability that is perhaps heightened by the experience of migration and its demands to cross into multiple territories. General medicine is asked to stretch wellbeing to include the psychological, the economic, the social.

It's impossible not to think of Roque Dalton's most famous poem at the end of this section, and remember his last lines,

> los eternos indocumentados,
> los hacelotodo, los vendelotodo, los comelotodo,
> los primeros en sacar el cuchillo,
> los tristes mas tristes del mundo,
> mis compatriotas,
> mis hermanos.
>
> [the eternally undocumented,
> the doeverything, the selleverything, the eateverything,
> the first to draw the knife,
> the saddest most sad of the world,
> my compatriots,
> my brethren.][1] (Dalton 1988, 200).

His "Poema de Amor" [Love Poem] is an ode to Salvadorans working outside El Salvador, who are obliged to "doeverything, selleverything, eateverything." In El Ocotal, doctors embrace "todología" in the spirit of having to perform all roles required to face the perils of ill health, which are the perils of life.

2.3 Chasing Prescriptions

With a mandated average of seven minutes per visit, doctors in public health services in El Salvador could not even begin to listen to the life stories patients bring to Doctor Cardona's clinic. Remittance clinics like Doctor Cardona's allow for a different kind of medicine, they change the conditions of possibility inside the clinic from seven minutes to an hour, from definite borders between health and "everything else" to less definite ones. But the intensity of requests patients make inside rural private clinics takes me by surprise and makes me wonder how these requests shape the medical space. In this section I want to pause on the medical practices sustained at the moment of the request and think about what the act of asking may be doing within the clinical space. I turn here to a specific task doctors are asked to perform in the clinical encounter: prescribing drugs.

Before coming to El Ocotal I spend time interviewing patients at a clinic in another geographic area with similar demographics, but without the difficult terrain and lack of transport that marks El Ocotal. At the clinic of Doctor Boris Santos (always called by

1. My translation.

his first name by patients and colleagues), I meet José, who lives alone and has come from a nearby village about an hour away. Speaking in a low tone swallowing words between breaths, José says he has come to the clinic of Doctor Boris because he has difficulty breathing. I strain to understanding him and look at his expression for extra clues. When I ask who takes care of him, he says he has a son that visits him once a week, and his other three children live in the US but also help. His son living in the US is currently without work, and one of his daughters had an accident recently, and so both are unable to send remittances for now. His other daughter migrated to the US with the help of her husband, and she almost never sends money and almost never calls. When he first started suffering from his lung problem he went to Dr. T, a doctor I don't know, and had good results with an injection, so he went back a few months later to get another injection. Again, he felt better. Then he asked Dr. T for the prescription so he could get it at a pharmacy and not pay for the consultation, but Dr. T denied him the prescription. He laments not remembering the name of the medicine and says he will never visit Dr. T again because he felt the doctor just wanted to make money off him.

When his breathing problem worsened, he went to clinics in Usulután, a modestly large city saturated with private medical specialty clinics and small hospitals. He returned to see another local doctor, Dr. R. He again got the injection that makes him feel better, and again asked for the prescription, but Dr. R instead offered to continue administering the injection in his clinic for $15 any time he wanted. He never returned and instead is now using natural medicine. His daughter in the US sent him what I think may be a nebulizer and bought him a gas stove so he would not have to inhale the smoke from the wood stove, which she thought was the culprit in aggravating his lung problem. He tells me he dreads to carry the *chimbo* (gas canister) all the way to his house, which includes a fair bit of walking, and sometimes reverts to using the wood stove. He has heard really good things about Doctor Boris, and says he will give him three chances to see if he can improve his breathing problem.

Small primary care clinics like Doctor Boris's many times sell their own medicine. Doctor Cardona doesn't, but Doctor Boris does have a small dispensary. He stocks the

dispensary with a variety of medicine that he trusts and sells at quite affordable prices. His "pharmaceutical rep" is a man that has a truck and is part of a network selling and buying lots of donated medicine that non-profit organizations can't use because they don't have a clinic. Curiously, some of the medicine that arrives has CVS or similar labels, and comes in packages of large unit counts. This is the only clinic I encounter getting medicine this way, most other doctors I interview acquire the medicine they sell the traditional way, through pharmaceutical reps working for national and international of manufacturers and distributors. But the practice of selling pharmaceuticals inside the clinical space, or of selling medical consults inside pharmacies, is frowned upon and became outlawed in the 2009 Health Reform. Given the conflicts of interest that arise when physicians get kickbacks from pharmaceuticals, or when treatments are bound to the profits ensured by moving only certain inventory, the government has chosen to legislate the practice. The problem of José not being able to get the prescription from his doctors is precisely the problem the new Medical Drug Law[2] tries to address.

José narrates his request in terms of cost and choice, but what does the request itself do? What does asking doctors for the prescription do? José's request for a prescription asks doctors to make evident their relationship to their patients in economic terms, and in this way it lays bare the economic nature of medicine. His request for the prescription embeds medical practice in an economic network in which the patient, the doctor, and the pharmacy participate. But also it asks doctors to be ideal doctors without economic interests in the same way the Medical Drug Law does. According to José, their response either situates them as selfless and ethical when they offer the prescription, or as self-interested and abusive when they don't. The request for the prescription operates as a way to test the ethics of the doctor and his commitment to the economic and health wellbeing of José.

The request also reduces the role of the doctor to a specific space of the clinical encounter—the moment of diagnosis and prescription of treatment. José is asking for the

2. The "Ley de Medicamentos" (Decreto 1008) was approved by the Legislative Assembly (Congress) on March 2, 2012 while I was conducting fieldwork and has been implemented slowly. It is part of the 2009 Health Reform and the National Public Policy on Medical Drugs.

prescription so that he can go to the pharmacy to have the injection administered there, thereby eliminating his need for the doctor as administrator of treatment. For José the doctor diagnoses and prescribes, but is not necessary in administering and maintaining the treatment. When the doctor insists on keeping the latter role, José sees him as a self-interested doctor that takes advantage of him. The demand for the prescription separates treatment delivery and administration from treatment selection and diagnosis, an arrangement that reduces the role of the doctor rather than expands it. The prescription-denying doctors resist the limited role José demands. In denying the prescription perhaps doctors insist on their own existence and authority as "todologos," and resist being effaced as important nodes in the making of boundless medical bodies. José's request for the prescription expects only one ethical outcome however, the doctor must provide the prescription to prove his own selflessness.

But perhaps there is no prescription to be given! Perhaps the treatment is the injection itself and not the effectiveness of the biochemical interaction with the body of the solution injected, in which case there is no prescription to be filled at a pharmacy. There is a successful treatment, but maybe there is no medical drug, no pharmaceutical, no biochemical component. José does not doubt the ability of the doctor or the efficacy of the treatment. In fact, precisely because he finds the treatment efficacious he wants the prescription. Asking for the prescription requires doctors to operate only within the logics and ethics in which the curing effects of the treatment must be contained in the pharmaceutical, anything else may be charlatanism. In the separation between delivery and selection of treatment, the possibility for the injection itself to improve the wellbeing of José becomes compromised.

But the act of asking and of responding does more than complicate what may be making José feel better. In asking doctors for prescriptions, José affects and enacts doctors. José makes doctors act, and in that acting they become. Furthermore, the request makes evident how treatments are not independent objects, detached from the actions and expectations of doctors and patients. They are not only objects tested and made in the lab. José's chase for a prescription, makes the prescription something to be

obtained, purchased, coveted, and desired. In that coveting he also enacts his own role as patient, as agent, as remittance recipient, as father of children in the US. In his constant chase for a prescription he becomes ever more present within the network the prescriptions instantiate. While it may seem that the power relations between the doctor and patient revert as José ultimately does not return to the doctors that deny him prescriptions, the clinical space is upheld as free of economic interest and able to legitimately determine the cure for the suffering body. In this sense, doctor and patient are subordinated to the logics that separate wellbeing from substance. José, not the doctor, makes the doctor be a drug selector separated from the process of drug administration, monitoring, and patient care.

2.4 Performing Examinations

There is another kind of request I find quite compelling. In one of my earlier conversations with Doctor Cardona, we talk about telemedicine and medico-communication devices that could complement the phone call for patients in the US and in hard-to-reach areas in El Salvador. After talking about the issue of cost and the ubiquity of phone calls across the country, he says the biggest problem with introducing devices allowing doctors to diagnose at a distance would be the absence of touch. He stresses, here patients want to be touched. I transcribe here part of the interview.

> El paciente salvadoreño no está para eso todavía. El quiere que lo toquen. Aquí es muy importante que el paciente sea tocado por el médico. Aquí se usa mucho la palabra "no me va a alumbrar". Entonces es muy necesario poder examinar al paciente. [...] Y es por eso la desconfianza de los pacientes al servicio público. [...] Cuando yo estaba en la unidad de salud yo veía 70 pacientes diarios. [...] Hay pacientes que yo sí los examinaba, pero había pacientes que no. [...] La gente empieza a desconfiar a ese tipo de consulta. Le gusta que lo toquen, que le oigan sus pulmones. Aquí en la consulta le tengo que confiar que a veces hay pacientes que yo sé que no tengo que examinarlo, con lo que el me contó yo ya tengo el diagnóstico, pero lo paso a la camilla para tocarlo. Si no, no voy a hacer un buen trabajo según él.
>
> [The Salvadoran patient is not ready for this. He wants to be touched. Here it's important that the patient be touched by the doctor. Here a word often used is "aren't you going to illuminate me." It's necessary to be able to examine

> a patient. This is why patients do not trust the public service. When I was at the public health clinic I used to see 70 patients daily. There were patients that I did examine, but there were others that I didn't. People start to distrust that type of medical checkup. The patient likes to be touched, to have his lungs heard. Here in my clinic I must admit there are times there are patients that I know I do not have to examine, with what they told me I have a diagnosis, but I move him to the examination table to touch him. If I don't, I won't do a good job according to him.]

Doctor Boris also talks about patients wanting to be touched with the same emphasis Doctor Cardona puts on the word touch. This is not the first conversation I have with Doctor Cardona about *alumbrar* (to illuminate, to light up, to give birth, to elucidate). He admits that he does not exactly know what the term means for his patients, but gathers it's about being examined, specifically examined by auscultation.[3]

> [A]quí realmente pues el paciente se fija mucho en el equipo que uno tiene para examinación, por ejemplo, ve'a. El paciente se fija mucho y el mismo paciente dice: "No me va a alumbrar". Hasta esta fecha yo no sé a qué se refieren cuando... Tengo pena de preguntarle ve'a, este, a qué se refieren cuando dicen: "No me va a alumbrar doctor", entonces nunca he entendido. He entendido que "alumbrar" es que les oiga su corazón y sus pulmones. Entonces, se fijan en eso, se fijan en el equipo que uno tiene, su, su, su, su forma de, de, de, de examinar, vaya, eso.[4]
>
> [Here, well, actually the patient pays a lot of attention to the equipment that one has for examination, for instance. Right? The patient pays attention and even says, "Aren't you going to illuminate me?" To the present day I still don't know what they mean when... I'm embarrassed to ask them, right, eh, what they mean when they say "Aren't you going to illuminate me doctor?" so I have never understood. I've understood that "to illuminate" is to listen to their heart and their lungs. So, they pay attention to that, they pay attention to the equipment that one has, to one's form of examining.]

He points to the otoscope and ophthalmoscope when he says patients pay attention to the equipment and form of examination. The request for *alumbrar* is not so surprising given

3. Auscultation, or to auscultate, means to listen to the lung, heart, or other organs. Patients and doctors in El Salvador often use the equivalent word in Spanish, *auscultar*, although patients often degenerate the word to *esculcar* (to search or skulk).

4. As many times as I have heard the noisy recording I still cannot discern how he transitions from stating he does not know, to stating he knows what patients mean by "alumbrar." The audio seems to skip at that moment.

that the otoscope and ophthalmoscope are indeed illuminating devices, they have a light source meant to illuminate the fundus of the eye, and the ear canal or eardrum respectively. The devices are often used in a routine examination along with the stethoscope, and the skilled palpating of the body in precise ways and places.

The question "¿no me va a alumbrar?" [aren't you going to illuminate me?] has turned into a "word" in Doctor Cardona's narrative, perhaps suggesting its commonality in the everyday clinical setting. Although in his narrative it's not clear if the phrase is a question or a statement, I gather from all other conversations that it's usually a command "alúmbreme" or a question "¿no me va a alumbrar?". When Doctor Cardona timidly ventures to offer his understanding of the term, he says *alumbrar* means "to listen" to the heart and lungs, to auscultate, but he also links the term to touching in his longer discussion. *Alumbrar* seems to have to do with sight as well since it's a literal reference to light. In this sense, the term encompasses the elements of a clinical examination that center around the inspection of the physical body through specialized medical devices attached to the physician's sensing body, to his eyes, ears, and hands.

In Doctor Cardona's clinic patients expect, perhaps even demand, to be examined in a very particular way—prosthetically, with devices connected to the senses of the doctor. Patients want to be touched, their eyes and ears to be seen, their lungs to be heard. It is not until then, that a medical consultation has occurred. The diagnosis based on the doctor's ability to fit their narrative of symptoms into an already catalogued medical case is not enough, they demand their diagnosis to be linked to their material body. To do a "good job" as a doctor, indeed to *be* a doctor in El Ocotal, Doctor Cardona must touch, listen, and see the body with medical devices. Such requests could be construed as a demand for the doctor to treat "the body proper" of empiricism, the unmediated concrete body. However, I think, when patients ask doctors to be proper doctors, they are also asking to be proper patients—to be read through the language of medicine, through the devices and the trained hand, eye, and ear that can recognize the expression of known diseases. They are asking not to be concrete bodies but rather to be the abstract bodies of medicine. They ask for a hand that can identify a hard abdomen, an ear that can

distinguish a fast heartbeat, an eye that can recognize a blown eardrum. It is by going through the motions of the examination—a choreographed practice involving tools and devices, and the prescribed and coordinated coming together of bodies—that doctors and patients become present to each other. In the moment of the examination, the body becomes present.

In asking "¿no me va a alumbrar?" [aren't you going to illuminate me?] patients resist diagnosis without auscultation and palpation, and demand the discernment and classification of pathology to be the result of clinical practice. Here diagnosis is constituted in clinical practice, precisely in the subjective medical expertise of the clinician. They elicit the embodied perceptiveness of the trained senses of the doctor to diagnose their ailment. In asking for an examination with the senses, they ask for the doctor's engagement with the qualities of their bodies. Their bodies cannot be obviated, and neither can the doctor's subjective sense-based skill. Clinical practice in this case is about bodies becoming engaged, becoming involved with each other in attentive ways.

Studying the literal meaning of the term *alumbrar* in Spanish might lead us into interesting speculations about the possible expectations of the clinical encounter in this case. The verb in conventional Spanish means to illuminate, to light up, to give birth, to elucidate. None of these standard meanings make sense in the way it is used in Doctor Cardona's clinic. With a little imagination, perhaps all of them do. Since a human eye needs light to be able to see, a body needs to be illuminated with light in order to be seen and to be diagnosed. But maybe part of the clinical encounter requires being illuminated with medical knowledge, or with spiritual guidance. Perhaps the body is coming into being, in the sense of birthing itself as a patient. Perhaps they are asking doctors to elucidate, to explain their disease and treatment, or maybe their bodies are the ones that elucidate, make clear the disease. The term is quite local; communities in the western part of the country do not seem to use it, and even Meza (2008) does not annotate it in his dictionary of Salvadoran vernacular, one of the most recent and complete compilations of regional colloquialisms. Doctor Cardona has a definite response to the command/request, he is clearly mobilized to be an examining doctor, to come within inches of the patient, to

breath upon them, to touch their sensitive abdomen, to command them to breathe deeply. These patients seem to be asking to have a light shone upon them, and as doctors do shine that light, the patient comes into the spotlight of the theater of the clinic performing the star role. In that spotlight, they are present.

Although Doctor Cardona does not give clinical value to the physical examination when he already knows the diagnosis from the narrative of symptoms, he acquiesces to the request and moves the patient to the examination table to touch her. By acquiescing, he gives social value to clinical touch. For Doctor Cardona the value in touching the patient is not in confirming the pathology, or discerning its causes, rather it's in the effects of his performative engagement with the body of his patients. In acting out the examination, he becomes a doctor doing a "good job." Performing a "good job" is not only important in terms of his legitimacy as a doctor, but also in terms of his ability to effectively improve the health of his patients. He is ethically bound to perform the examination for the wellbeing of his patients, even when diagnosis is not the result of the examination. Clinical touch forms part of a wider network of health improvement inextricably tied to the social relations of health. In the moment the patient upholds biomedicine's empiricist tradition (by asking for a physical examination when none is needed for diagnosis), the doctor upholds the health value in the performance of clinical touch. In this moment, the space of biomedicine is transformed.

Clinical touch in this case does not form part of diagnosis, but forms part of healing and wellbeing, of being a good doctor, one concerned with the patient's health. In this sense, touch is not about the embodied perception of disease, but rather about the sensing of bodies. Sensing here figures in two ways, as feeling in terms of sentiments, and as making sense (Massumi 2002; Manning 2007). The doctor's touch is no longer searching for disease expressions on the medical body of his patient, but rather, is touching to create the sentiments of trust, concern, and wellbeing. Simultaneously, he is making sense, figuring the needs of his patient. He senses, rather than touches. As the medical body of the patient gives way to the social person, the clinic gives way to a larger social space.

In the waiting room of Doctor Boris, patients repeatedly tell me, sometimes emphat-

ically, they like to come to here because he touches them. Doctors in other clinics, when answering why patients come to small private rural clinics, mentioned touching their patients. They weren't referring to palpation in the moment of the examination, but to the handshake, gentle placing of the hand on the arm or shoulder during a welcome or farewell. This kind of social touch has been found to be fundamental in the formation of trust and social bonds in specific social and cultural contexts. Such conclusion seems to sweep across a wide range of disciplines, from the social sciences studying the formation of social bonds, trust, and intimacy, to the biological sciences and medicine studying the skin, brain, sensory receptor cells, and neurotransmitters. In one interdisciplinary study reporting on the "affective dimension of the cutaneous senses in the transmission and processing of social information," the authors state that the "Effects of touch in social interactions have been found to increase liking of a person or place, and to facilitate the footing of trust or compliance" (Morrison et al. 2010, 306). Unsurprisingly, patients mention touch and trust as reasons why they like and choose their doctors. Doctors in the remittance clinics I visit often clutch with both hands the hand of their elderly patients to greet them, give short embraces and pats on the back. Patients touch doctors too, they grab their hands thanking them, and touch their shoulder or their arm greeting them. In the economy of touch that emerges, the clinic functions as a space where bonds are formed and sustained, aiding in the organization of local social arrangements.

Interestingly, touching is not a behavior that goes unmentioned or unnoticed. What surprises me is the constant talking about touching, the asking to be touched, the announcement of being touched, the making touch evident and visible. There seems to be a small discursive aspect of touching, an intentional naming, requesting, and announcing of touch. There is no institutional incitement to speak about it, but rather a tangential mention of touch as doctors and patients talk about what is important in the clinical encounter. But by explicitly articulating touch, patients and doctors make it an operand of social arrangements. The clinic through the economy of touch redistributes social relations, as only those that can come to these private clinics, remittance recipients, participate in this requesting and claiming of both clinical and social touch. Clinical and

social touch seem to be intimately bound by a desire to be touched, a desire for the body to be diagnosed, treated, dealt with, reckoned with. The condition of this desire, I think, cannot be separated from the larger logics of remittances and migration. In the impossibility to touch their relative and be touched by them, to sense the pressure of their hands upon theirs, the condition for their desire for touch rests. As everyday touch becomes uncertain in aging alone with far away relatives becoming more distant as time goes by, the desire for touch garners its own strength. These patients literally ask to be seen, to be shed a light upon, as well as to be touched, to be felt.

2.5 Requesting an Emergency

I join the public health mobile unit on several other trips to neighboring villages and get to know Doctor Jimenez, the internist and most senior physician of the team. He is full of energy and optimism, especially regarding the new healthcare policies introduced with the 2009 Health Reform. He feels a personal sense of responsibility to make the Reform a reality, and his idealism is infectious—when he talks about what the ECOs work against and how they will repair long-standing problems, the young women in the team and even the surly gynecologist seem to believe. He is finishing a master's degree in Public Health at the Jesuit university in San Salvador, and crosses more than half the country for three hours once a week for his Thursday class. His speech full of unfamiliar colloquialisms, fills our interviews with laughter, confusion and surprise. He spends most of his time in the public sector, but has his own private clinic, which he attends before seven in the morning and after four in the afternoon. The first time I meet him he tells me a story about the ethical dilemmas he faces in the private sector—the challenges in medicine brought about by the relationship between remittances and healthcare. I can't record him during that first meeting, so in our following meetings I ask him to tell me the story again. It seems he has told this story many times before, the succinct quotes of his characters seem well rehearsed. He nevertheless seems to narrate it with the same sense of shock and frustration he initially felt. The following is my paraphrasing of a long interview along with details from my notes taken the first time he told me the story.

One day a colleague asked him for an evaluation to admit a patient at a private hospital. Doctor Jimenez went to see the patient, an older woman with grown children, and found her out of sorts. He recalls her saying, "Usted ingréseme, usted déjeme porque sino mis hijos no me creen, y yo necesito estar ingresada 'pa la remesa, 'pa que me manden" [Admit me, leave me here, because if you don't my sons will not believe me, and I need to be admitted for the remittance, so that they send me (money)]. Initially he decided to evaluate the patient in case something was indeed wrong. But he found the patient was stable, all the vital signs were fine, blood pressure fine, heart frequency fine, he did not have any evidence that this patient was in any mortal danger. But he nevertheless admitted her to run more tests just in case something more obscure came up. The lab exams came back; the electro-cardiogram, chest x-ray, and all electrolytes were normal. The next morning he told the woman she was fine and could go home. The woman pleaded, said she needed to stay, she felt pain and accused him of not understanding her pain. Doctor Jimenez called his colleague and told him that he did not see a motive to keep her, he did not think it was ethical to keep her just because she wanted to be there. His colleague sucked his teeth and told him to not discharge her. He remembers her family saying, "Nosotros le estamos pagando, usted cobre" [We are paying you, you just bill us]. They didn't say that exactly, he tells me, but their message was, "Pues sí doctor, pero si al final y al cabo la cuenta la vamos a pagar nosotros" [Well doctor, in the end it is us who is going to pay the bill]. But he couldn't do it, he released the woman and told his colleague that it was up to him if he wanted to admit her again. But the colleague was a relative of the patient and was only a general physician, so he could not admit her.

In a tone of frustration Doctor Jimenez says that after her release "[ella] me siguió acosando, llamándome por teléfono que quería que la volviera a ingresar" [she kept harassing me, calling me over the phone that she wanted to be admitted again]. She insisted, "Quiero que me ingrese doctor, mire que yo me siento mal y es que estoy descompensada, estoy mal, estoy grave" [I want to be admitted doctor, look I feel bad, I am decompensated, I'm not well, I'm seriously ill]. She said she felt a terrible anguish, and the doctor tells me that he had prescribed anxiety medicine and antidepressants when he released

her the first time, but she was not taking the medicine. He concludes that she just wanted to be admitted to the hospital, "Eso es lo que quería, estar ingresada . . . porque sus hijos están en Estados Unidos" [That's what she wanted, to be admitted . . . because her sons are in the United States]. I ask Doctor Jimenez how did he find out that her sons were in the US and he tells me that the first time she was admitted she told him,"Usted sabe, si uno no está enfermo a veces ni caso le hacen, y ellos me van a mandar para ésto, ellos van a pagarlo todo doctor, ya hablé con ellos" [You know doctor, if one is not ill sometimes they do not pay attention, and they are going to send for this, they are going to pay for everything doctor, I already called them].

But Doctor Jimenez did not re-admit her, so eventually his colleague called and told him the patient was in the hospital again and she needed to be admitted for a few more days. Doctor Jimenez this time asked him what was his diagnosis, and with irony says "Neurosis?" His colleague was relentless and asked him to admit her. He tells me, at that moment he decided to talk to her relatives and told them that she did not have a serious problem that warranted hospitalization, the problem was affective, emotional. He offered his own experience with his own migrant family, and told them "Miren, yo tengo a mi hermana en Estados Unidos y créanmelo que veo como ellos trabajan y les cuesta ganarese su dinero . . . yo no me prestaría para hacerle algo así" [Look, I have my sister in the United States, and believe me, I see how they work and how difficult it is to earn their money . . . I would not lend myself to do something like this to her]. He recalls telling the patient that she must cooperate and help the situation, he understood that she was in pain and was not denying she felt pain, but she was stable and had no medical criteria to be admitted. He explains that doctors work with specific criteria for hospital admissions and besides, he told them "me imagino que a pesar que tenga muchos hijos allá, está la crisis económica. Usted imagínese cada ingreso de la señora cuesta $500, $600" [I imagine that even if she had many sons and daughters there, there was the economic crisis. Imagine, each hospital admission of this lady costs $500, $600]. The relatives listened and said they understood, the doctor told them "yo me siento mal" [I feel bad]. He told them they needed to work the affective, the emotional aspect of the problem, and asked them who

did she live with, did they keep her company, but learned she lived alone and even though the relatives (none of which were her sons or daughters, sisters or brothers) lived close by, they did not visit. The colleague was furious, and accused Doctor Jimenez of pretending he was honest and told him from now on he would call another colleague. They haven't spoken since.

In one of the other two stories he told me about situations in which he is called to hospitalize patients without a medical criteria to do so, he got caught up in an event at his church and had a series of other problems in reaching the hospital. When he eventually reached his colleague over the phone, the colleague was mad and said, "Ah no, a vos como que te sobra el pisto que no querés. Ya le dije a (otro doctor) y él la ingresó" [Ah no, it seems you have so much money that you don't want. I've told (another doctor) and he admitted her]. Afterwards he analyzed the situation and told himself, "en el fondo yo creo que esto fue el motivo para que yo no cayera en eso" [in the end I think that was the motive for me not to fall into that]. The motive he was referring to was the event at his church. He felt saved from temptation of earning at least $100 a day for a hospitalization.

Doctor Jimenez's story continues to intrigue me. No other doctor ventures into a similar candid account about the ways doctors are implicated in complex medical practices that may seem unethical. On the flip side, I hear many patients protesting the ways they feel taken advantage of by doctors when these notice they receive remittances. Doctor Jimenez tells the story as a complaint about the terrible state of affairs in medicine as a result of migration—on the one hand, there is the abandonment of elderly women and disregard for their affective needs, and on the other, the unnecessary medical services provided by unscrupulous doctors.

Evidently, the ethical dilemma unsettles Doctor Jimenez. The language of "falling into temptation," and of being harassed by patients, reveals his moral quandary and sense of powerlessness against his own greed. He feels harassed into declaring false medical needs, but serendipitously, an event at his church "saves" him from "falling" into doing so again. In the story, the uneasy, but eventual admission of patients into hospitals captures his own, and medicine's, vulnerability against the "corrupting" power of remittances. For

Doctor Jimenez, remittance recipients have taken a hold of the medical emergency space, forcing doctors to act either against their will, or act willingly but unethically.

Doctor Jimenez is asked to ring the emergency medical bell that only medicine can ring, to certify with medicine's expert knowledge the impending finality of death. In doing so, the emergency is able to mobilize faraway relatives into "doing something." One patient in Doctor Boris's clinic says that one has to *meniarse*[5] (to move or sway the body, to rapidly move from place to place, to rapidly move something) for one's sick relatives. She talks about going with her sick daughter from the public health clinic, to the private clinic, to the public hospital, back to another private clinic. Even when she doubted the usefulness of the public health clinic, she nevertheless endured the long waits, bureaucracy, and discouragement. When she finishes listing the places she visited, almost exhausted, she pauses possibly looking at my permanently frowned brow and says, "¡Hay que meniarse, no hay que dejar!" [One has to move, one cannot stop!]. The latter phrase is an incomplete statement. In this case possibly, "No hay que dejar de hacer/moverse" [One cannot stop doing/moving]. Her child's illness constitutes a dramatic disruption of her life world, and as such, mobilizes her into immediate, urgent search for ways to bring back health and order into their life. Doctor Jimenez's patient asks medicine to do what only medicine can do, to *certify* her illness and its gravity, hoping this will make her *be* in the lives of her relatives as they move their bodies, and reach toward her. According to Doctor Jimenez, the medical emergency is created to move the woman's relatives into action by sending remittances and making a call. At that moment, medicine has made the woman present in the lives of her relatives in the US. No longer is she a distant memory, or an aging picture in a wallet, she is with them as they re-act and become with her in her demand.

In order to understand how medicine can mobilize relatives into immediate action, we need to understand what is an emergency, and how does it elicit a response. Gesa Lindemann (2007) argues that biomedicine operates as a "border regime" between death and life, and as such needs a hermeneutics of the physical body, which she finds in the

5. *Menearse* in standard Spanish.

practices of diagnosing brain death in ICUs. Medicine's decisive problem is "the difference between life and the 'prealive' and respectively the 'postalive' states of a human body" (Lindemann 2007, 51). Medicine's special ability to certify the moment of death is accompanied by the moment before death, when death can be stopped. The moment of impending death is the moment of alarm that the woman seeks when she asks Doctor Jimenez to please admit her to the hospital. To be admitted is a certification of being close, but not yet in the "postalive" state. It is precisely the *capacity* of stopping death that makes the emergency. The emergency is constituted in the possibility of being able to do something to stop death. The emergency bell is rung to make others act because something indeed can be done to save a life. As a border regime, medicine is not only able to determine the "prealive" and "postalive" moments, but also the degrees of urgency approaching death, how close is the patient to death, the degree of the possibility to stop death. This *moment* and *capacity* are what Peter Redfield (2005) says accompany a crisis, which he defines as "a general sense of rupture that demands a decisive response" (337). I borrow this sense of crisis to understand the work the emergency does here.

The moment of the emergency suspends the ordinary, it ruptures the routine of daily life as it demands extraordinary immediate action to intervene and stop death. More accurately, the rupture of the social order starts with illness itself, and the emergency only asserts the gravity of the situation and need to act promptly. In his first published essay, Arthur Kleinman (1973) aptly locates illness and death as disruptions to social worlds. Concerned with understanding how healing practices operate cross-culturally, he explains that, "The healing dialectic has been considered effective when the bonds between the sick individual and the group, weakened by disease, are strengthened, social values reaffirmed, and the notion of social order no longer threatened by illness and death"(207). Illness is theorized as that which "weakens" the "bonds" between the sick and the group, and healing as that which "strengthen" them. Illness as a disruptor of relations, dissolver of social bonds, presents perhaps the most dramatic of all social events. Understood as such, the woman seeks a hospital admission precisely because it promises to strengthen social bonds, at least according to Doctor Jimenez. In my reading of Doctor Jimenez's

narrative, his patient seeks the space of the hospital, a healing practice, to restore her precarious and uncertain bonds with her relatives and her local social world. Medicine is sought for its capacity to reestablish bonds, for its ability to make relatives re-act, and in this way strengthen and reestablish the social order in which the woman is a mother, a loved one, a body alive.

Kleinman continues to explain that healing is considered effective "when the individual experience of illness has been made meaningful, personal suffering shared, and the individual leaves the marginal situation of sickness and has been reincorporated in health or even death back into the social body" (Kleinman 1973, 207). The actions the emergency calls for involve the reincorporation of the sick to their social world, even after death. Relatives are asked to share suffering, and make meaning of her hospital stay. Relatives and doctors are not only asked to prevent death, but also to prevent social death, to prevent the social bonds to completely disappear. The site of the hospital is sought to undo the loneliness that results from social abandonment, the "affective" problems that Doctor Jimenez names.

Interestingly, the reincorporation of the woman into her social world does not depend only on the response from doctors, which make her present as a patient. In her desire to be admitted to mobilize her relatives, she asks doctors to craft affects to make her relatives re-act. The doctors' participation in the construction of the emergency, shifts the nature of the emergency, and places the burden for action onto the relatives. Given the relatives are in the US, they can't do the kind of going from hospital to hospital that the woman in Doctor Boris's clinic did with her child, nor can they do the kind of advocacy that an ill person in the hospital might require. Doctor Jimenez insists the woman wants remittances, but it's unclear if she ever gets any cash. When trying to persuade Doctor Jimenez into admitting her to the hospital, the woman and a local relative, tell him that relatives in the US have agreed to settle the bill. In my investigation of the circulation of remittances, I learned that small private hospitals in this area often receive payments directly from relatives in the US, bypassing the local patient altogether. What the emergency asks relatives to do is perhaps most obviously, to foot the bill, but

most importantly, to show concern. Paying the bill may amount to concern, but the woman is also asking for engagement, for involvement, for assertion that she is still here, not only alive but present. She wants to be reckoned with, to be unable to be dismissed, to be "reincorporated back into the social body."

But why must relatives respond? What presupposes their obligatory response? If their relation with the patient is already precarious and uncertain, why would they respond to a call saying she has been admitted to the hospital? The relative is responding to the request to stop the impending death of a relative, not an unknown other, which situates the response within the logics of filial obligation rather than the logics of civic responsibility, or humanitarianism. Many relatives, not just children or parents, are called during a health emergency; sometimes even non-relatives are called to help. But this obligation is not solely the effect of a gift economy within kinship networks, it is also the obligation instantiated by the ethical requirement to stop the death of a relative.

This ethical requirement to stop the death of a relative is traversed by biopolitical responses in interesting ways. In a sense, "to stop death" is the common-sense of medicine, the result of biopolitical projects "to foster life" of modernity, as proposed by Michel Foucault and generations of scholars investigating the effects of the liberal state. Medicine in the liberal state, as an institution of public health, population management, and workers' wellbeing has been charged with the ethical responsibility "to stop death." But as the social and political institution to stop death fails in El Salvador, in the private and the public space, then the responsibility rests on individuals acting on their own. The appeal to the relative occurs in the context of political institutions and civil society that have failed to respond to the crises of war and migration that condition the desperation of the woman requesting the construction of an emergency. Humanitarian reason as it draws civil society to act in response to a crisis, through notions of citizenship, civic duty, or humanitarianism is not elicited by the woman because it cannot be mobilized in this space. The only one that can be mobilized is the most intimate relationship, the one that cannot refuse to respond to the crisis: the relative. The doctor is not the figure that can act to stop death, he can certify the emergency, but the one called into action is the relative.

2.6 Conclusion

In the sociology and anthropology of biomedicine, reflections on the authority of doctors and the docile bodies of patients abound. Many such reflections emerge as a call to reform clinical practice in order to give patients back their "voice"—a voice silenced at the moment in which disease became a condition of the human body able to be scientifically known only through the trained medical gaze. Gregory Pappas, a physician anthropologist writing on different theoretical perspectives concerning the doctor-patient interaction, reflects on his own medical training in the US as follows,

> What I as a student and many of the medical students I later helped train found most difficult about clinical work was the assumption of control over the patient's body during the exam. [...] Descriptions of the simple techniques of percussion, auscultation, and palpation do not convey the intimacy of the physical exam, which unlike even sex, requires near total surrender of the body. The patient becomes the docile body to be manipulated and explored; robbed of autonomy so completely as almost to obliterate the meaning of being an actor. (Pappas 1990, 202).

In the US, the notion of patients "robbed of autonomy," reduced to docile manipulated bodies, has been the concern of social movements denouncing denied agency in the patient-doctor encounter as a form of social exclusion since the fifties. Pappas goes as far as calling the "obliterating" power of doctors to be the "tinder" for social change (202). Doctors in El Salvador are no strangers to such political calls. When Doctor Jimenez emphatically repeats to his patient, "yo le creo" [I believe you], he stresses his belief in what the patient says she feels, and his commitment to acknowledging her feelings as part of the "humanization" he fights for in the clinical encounter.

Ironically, the kinds of acquiescence to the demands of patients in remittance clinics may horrify the advocates for the inclusion of patient voices. Under the framework in which the subjective voice of the patient is important, but the objective authority of physicians is determinant, the demands for prescriptions and hospitalization without "clinical criteria" may be seen at worse as manipulative, or at best, as indicative of a social need, not a clinical one. Under the medical ordering that determines clinical criteria, ailments that fall outside the boundary requiring a medical response, may fall under social

or psychological problems needing a social response. In the sections above I argue that clinical practice itself—examinations, injections, hospital stays—work outside their clinical boundaries to address social problems. Remittance clinics have the unique capacity to bring relatives into being to repair the crisis of kinship brought about by separation, migration, aging, reduced remittances. The crisis of presence for rural Salvadorans with families far away is a crisis of precarious social ties, a crisis of kinship, which I suggest can be "repaired" through the relations the clinic enacts.

Is there another way to think about the medical world of remittance clinics? In a special issue of *Body & Society* dedicated to STS conceptualizations of "the body," Mol and Law (2004) suggest that instead of "adding" the voice of the patient to medical knowledge, "Medicine should come to recognize that what it has to offer is not a knowledge of isolated bodies, but a range of diagnostic and therapeutic interventions into lived bodies, and thus into people's daily lives" (58). What if rural patients with remittances are not manipulating their doctors and their relatives with their demands, as Doctor Jimenez thinks, but instead are affecting and being affected, they are intervening into lived bodies? I want to briefly think with the notion of "learning to be affected" that Despret (2004) and Latour (2004) present in the same special issue.

Vinciane Despret elaborates the concept of "learning to be affected" through the story of Hans, a clever horse that in learning to see the almost imperceptible body movements of those that pose questions to him is able to provide answers. The questioners have learned to be affected by the horse and without their knowing, they move in such a way to get the answer they expect from Hans. Bruno Latour further elaborates on what this "learning to be affected" entails through an examination of how people can become "noses" through training their noses with odour kits. Latour, reading Despret, summarizes, "to have a body is to learn to be affected, meaning 'effectuated', moved, put into motion by other entities, humans or non-humans" Latour (2004, 205). I find useful the notion of "learning to be affected" after it has circulated through STS and gained a different way of organizing the world—one in which affect and emotions are not the subjective matter that opposes scientific practice. I want to stretch the concept to talk about the kind of

reckoning patients demand in remittance clinics. Patients make relatives act, and in that acting relatives become.

But patients also make doctors act; in fact, most of the chapter examines the ways doctors act. Relatives mostly only act by sending remittances. But doctors do a lot—they write prescriptions, give land advice, shine a light, touch the abdomen, shake the hand, authorize hospital admissions, refuse to authorize hospital admissions, disagree with colleagues, struggle with their own decisions. Doctors are affected by patients—they are moved, put into motion, made present. Patients do a lot too—they come into the clinic, ask for things doctors don't understand, return when they are touched, grab the doctor by the collar, bring gifts, dial phones, hear their last names. Patients too affect and are affected by doctors. I frame these actions as emotional, affective, social actions outside clinical categories. Can they be reframed as clinical actions, as ways of becoming with patients, with doctors, with disease? In this becoming with, doctors are not experts that discover disease, they are made as they are affected by patients. The woman in pain asking to be admitted to the hospital makes the doctor. The doctor does not exist outside this relation either. In the pain that brings the woman to ask for a hospital admission the doctor becomes present, just as much as the woman becomes present. This, I think, maybe an interesting way of thinking of the demands by patients and the acquiescence of doctors. They learn to become with each other, to respond to each other, making medicine a place and process enabling intervention in each other's lives.

Chapter 3

Making Doctors

Abstract. In the medical encounter of biomedical clinics in rural El Salvador, doctors as well as patients are subject to each other's ideas of health and illness, treatment success and medical care. The patient is not only the recipient of diagnoses, treatments, and biomedical understandings of body disorders, but s/he also shapes biomedical practices. The ways in which doctors respond to patients opens clinical care beyond the measurable improvement of physiological disorders or standards based on numbers of successful diagnosis or treatment adherence. In these clinics doctors "become with" patients as they learn to be affected through their attempt to make sense and make use of local ways to speak about, to treat, and to hold the body. This chapter investigates how rural conditions affected by remittances shape doctor-patient relations through the negotiation of specific medical therapeutic practices. I argue that the practices enabled by remittances in rural clinics *make* doctors who straddle the line that biomedical science draws to interpret symptoms, determine therapies, and define priorities, while teetering between contrasting logics that emerge from the demands of migration and remittances. Doctors are made in practices anchored in specific milieus, through the relation of large heterogeneous networks of subjects, objects and practices. This chapter is about how a doctor becomes a doctor in the rural Salvadoran remittance clinic, and what it is to be a good doctor under the stresses of local specific demands and biomedical general knowledge.

3.1 Introduction

Salvadorans living in the US traveling to rural El Salvador in search of healthcare seem to value biomedicine counter-intuitively. In the remittance-receiving rural areas I conduct interviews, I meet doctors and patients that emphatically qualify rural healthcare as "better" medicine than the technology-rich medicine offered either in the US or in San Salvador. Early on I start wondering what makes "better" healthcare in these areas, what constitutes "better" if not the commonsense of technology and progress. In my interviews in rural areas doctors and patients link "better" to the doctor's ability to understand the rural language of illness experience, and the "warm" medical interactions filled with human affection that oppose the "cold" relationships mediated by medical machines. The story doctors tell about their patients goes something like this: *They think the technology of the North dehumanizes, is all about money, and come to El Salvador for the human affect and attention they can get here.*[1] Salvadorans I interview in the US complain about the ineffectiveness of therapies, disregard and lack of understanding doctors have in clinics and hospitals in the US. Although the majority of the advertisements for medical services targeting Salvadorans abroad indeed mention medical innovation and high-end technology as a selling point, the returning Salvadorans I interview in rural clinics claim doctors here understand them and give them treatments that "les cae bien" [sit well with them], which make the trip worth the trouble.

Doctor Jimenez, the internist who has his own private practice a few yards away from his office in the state regional Specialized ECO,[2] thinks that Salvadorans return to receive health services in places like El Ocotal not just to reduce the high medical cost in the US but also to avoid unscrupulous doctors there. In one of our interviews he looks at the voice recorder and taps on the table with his finger, recording a loud knocking

1. The "dehumanization" of technology-rich biomedicine juxtaposed against "humane" traditional healing practices has been widely written about in medical anthropology literature. See Good (1994, 26–27) for a review.

2. The Equipos Comunitarios de Salud (ECOs) are mobile primary healthcare units prioritizing close-to-home family medicine, launched in "needy" municipalities as part of the 2009 Health Reform (MINSAL 2011). Many doctors work full time in the public health system in ECOs or other similar posts while at the same time attend their own private clinic before- and after-hours. This type of well established "moonlighting" is not regulated, even though patients complain that doctors encourage a visit to their private practice while undergoing examination in the public clinic.

sound. He is delivering a message to "them"—presumably those who he imagines to be my audience, perhaps anthropologists and medical doctors in the US, or more broadly *gringos*. He wants to make sure "they" understand that people from places like El Ocotal find doctors in the US untrustworthy, and prefer to contact their relatives in El Salvador to get personal recommendations for doctors. He says,

> [E]n el fondo yo pienso, y ahí se lo vamos a decir a ellos, que la gente latina no confía en los gringos, no confían. Ellos tienen una desconfianza con los médicos allá—que no les digan toda la verdad, que los quieran *destuzar* (estafar). Entonces ellos recurren al de la confianza de la mamá, "Recomiéndeme mamá, o tía, usted alguien de su confianza." "Ah el doctor fulano, él lo que es te va a decir, él no te va a andar mintiendo." Y también saben reconocer quién se los está bajando, "el doctor fulano es *pisterito* (codicioso)," ve'a, es *pisterito*, le gusta el *pisto* (dinero). "El doctor fulano es bien *pajero* (mentiroso)." "El doctor fulano no atina nada, por gusto uno va ahí." Todo eso se mueve, ¿me entiende?, en el ambiente. Ve'a, entonces yo creo que todo existe, yo se lo garantizo sin temor a equivocarme aunque no lo he estudiado, la gente de este país no le tiene confianza a los médicos de allá, no mucha.
>
> [In the end I think, and here we're going to say it to them, that latinos don't trust *gringos*, don't trust. They distrust doctors there—that they will not be told the truth, that doctors will want to *destuzar* (defraud) them. So they turn to the one that their mother trusts, "Mom, or aunt, recommend someone you trust." "Ah, doctor so-and-so will tell you what it is, he isn't going to be lying to you." Also they know how to recognize who is taking advantage of them, "doctor so-and-so is *pisterito* (greedy)," right? he's *pisterito*, he likes *pisto* (money). "Doctor so-and-so is a *pajero* (liar)." "Doctor so-and-so doesn't know anything, you go there for nothing." All of that moves, get it?, in the atmosphere. Right? I think that all that exists, I guarantee it without fear of being wrong, although I haven't studied it, people here don't trust doctors in the US, not too much.]

Doctor Jimenez is trying to draw attention to his patients' rejection of an enduring modernist-colonialist idea—that things are better in the North where technoscientific development promises health and prosperity, and perhaps even some sort of fairness. In contrast to that ideal, his patients think that doctors in the US often lie and take advantage of patients leaving them in financial ruin. It would seem he is contrasting untrustworthy US doctors to trustworthy Salvadoran ones. But a closer reading evinces a contrast not between the ethics of doctors, but between the networks in which doctors

emerge. Doctors in El Salvador can too be quacks, cheats, or be good for nothing. What makes the Salvadoran medical space more trustworthy is not some particular integrity, superior medical expertise, or cultural competence. In places like El Ocotal, Salvadorans can navigate the thorny medical labyrinth through the guidance of their relatives, making use of their experiences in building intimate relationships with doctors. Here they act through their relatives, benefitting from the accumulated knowledge of those they contact, especially those they may have sent remittances to be used in clinics. When Doctor Jimenez says, "all of that moves," he means to encompass everything that makes possible the medical intimacies which have rendered affected doctors, patients, and relatives; "all of that"—the heterogeneous actors and practices—which in the process of bringing together families, doctors, remittances, *sueros*, emergencies, creates encounters and networks of trust and intimacy.

The problem is not that Salvadorans in the US cannot make the same distinction their relatives make in El Salvador—that some doctors are cheats and others aren't—but that in El Salvador good doctors emerge in the network of their particular relations. Doctors are made good, honest, knowledgeable, trustworthy *through* the medical encounter in which remittances, migration, demand for pharmaceuticals or prescriptions, operate together. By saying that *trustworthiness is made in the medical encounter*, I do not mean to say that each culture has its own meaning of what makes a doctor trustworthy—in the US it may be scientific explanations of the mechanism of disease, in El Ocotal it may be touch in physical examinations—rather, I want to refer to the ways doctors are made good doctors through the negotiations and intimacies necessary to practice medicine here. A good doctor exists only through the mother's medical encounter, mediated by remittances and the relations these build. This is an encounter filled with the specificity of the demands of rural remittance medicine. This chapter explores the nature of those encounters, and the kinds of doctors that emerge within networks of trust built on the relations enabled by migration, family, and remittances.

My analysis takes language, local prescription practices, and affection in care beyond the framework of "culture" as an explanatory model for the quality of medicine Salvadorans

value, and moves toward a framework in which practices and materiality produce what good medicine and good doctors are. I take an STS approach that works to remove the scare quotes from *good* or *better* in the medicine practiced in rural El Salvador to unsettle the logic that creates a distinction between *belief* and *knowledge*, between "what good medicine is here" and "what good medicine really is". The undoing of the separation between the contextual and the general, attempts to trouble the structure that privileges abstractions that are meant to work everywhere, every time, where local beliefs can always be subordinated to universal knowledge.

The framework of "culture"—the attribution of meaning to experience, actions, or objects—has had an enduring prevalence in medical anthropology, and in the US it has entered clinical training with particular energy in recent years (Kleinman 2006; Kirmayer 2012; Willen and Carpenter-Song 2013). The early work of physician anthropologist Arthur Kleinman (1989, 1980) made evident how the *meaning* of illness experience of patients was crucial in successful diagnosis and medical treatment. For instance, what blood may *mean* for patients—what it represents in terms of sociocultural value for them—intervenes in body affections. As such, understanding the meaning of blood in specific cultural contexts becomes important for physicians trying to diagnose and treat bodies affected by those meanings (on blood see Good 1994, 88–66). The reality of body affections, it turns out, is not separate from the sociocultural context in which it occurs—bodies and their affections form part of, and are constituted in their sociocultural milieu.

In the case of El Salvador, understanding the cultural significance of *sueros*[3] in rural areas—the ways they represent modernity, economic status, and are associated with faster, and therefore more efficacious, drug delivery—could explain not only their preference, but also their asserted efficacy in treating a storm of ailments. But "culture" is also important to understand what physicians do, and why they do it. The physician's intravenous therapeutic practices could be explained by the local conventions determined by historical conditions of scarcity of expensive pharmaceuticals and ubiquity of saline solution, and

3. Intravenous saline solution therapy popular in private clinics and pharmacies in rural eastern El Salvador to treat lethargy, tiredness, weakness for instance.

the prevalence of gastrointestinal disease and its urgency for intravenous hydration, for example.

But the framework of "culture" does not allow to take patients and doctors seriously without qualifications—their actions seem to always need to be qualified as particulars that go against the general abstractions of universal medicine. And although it is valuable to understand the specifics, these Ocotal doctors and patients remain only a curiosity under this framework. To clarify, they remain a curiosity only when the incidence cultural meaning has on the body sits against something else, something more powerful that can always and generally be said to measurably affect the body—that is to say when *culture* is juxtaposed to *nature*. When doctors prescribe *sueros* for what they do through their cultural meaning, they challenge what *intravenous solution drips* are accepted to do medically, and end up being seen as quacks or swindlers. They are thought to violate the boundaries between *sueros* and *intravenous saline solution drips*, and disregard the ways that biomedical scientific evidence gains its meaning and power over cultural meanings. A study of the ways the cultural beliefs of rural patients and doctors produce prescription practices that go against internationally accepted clinical protocols, would dismiss the doctor's contribution to the wellbeing of their patients to the "placebo effect" of "culture" at best. Under this framework, Salvadoran rural medicine is considered "better" always in quotes, to distinguish it from biomedical prescription practices that take meaning in the discourse of evidence. How to take their practices seriously, without qualifications, without the shadow of what makes them exceptions, without the burden of defending the specific belief against the general knowledge? And how to avoid the problem of trivializing medical practices, an "anything goes" kind of study, while taking them seriously?

Cristiana Giordano (2014) offers a different kind of understanding of culture that does not suffer from the limitations I have outlined above. Culture as a form of translation in ethno-psychiatry, has the potential to "create a space for the acknowledgement of difference and provide a language that welcomes the incommensurability of worlds" (69). This kind of understanding of culture as translation, which "welcomes the incommensurability of worlds," does not subordinate the differences of rural medical practices to the abstractions

of biomedical knowledge. There is space for difference. I take another approach to think through the difference of medical practices and experience of health problems.

The work of STS (e.g. Stengers 1997; Latour and Woolgar 1986; Mol 2002; Law 2011) helps me to ask questions about medical therapeutic practices without submitting them to the overarching logic that would render the prescription practices of *sueros* to be a local practice without therapeutic evidence that could only be categorized as "snake oil." My concern is not whether treatments are fake or real, but how treatments become treatments through their practice as treatments. Furthermore, studies of science that look into the materiality of practices ethnographically help me pry open the "black box" the sociocultural takes in explanations that look into the effects of cultural meaning on the ill body. I propose to study the ways doctors become good doctors in rural El Salvador—the practices in which they *are* good. I argue that the relations enabled by remittances in rural clinics constitute situated doctors who straddle the line that biomedical science draws to interpret symptoms, determine therapies, and define priorities as they are entangled with the local demands of migration and remittances. This chapter is about how doctors are shaped in the interaction with patients, and how in the interaction they are made good, trustworthy, effective doctors.

I investigate how the demands of family members receiving remittances shape doctors and their medical practices. The chapter first looks at how the demands for translating the rural meaning of symptoms from the context of the patient to the context of medicine force doctors to relinquish the imposition of biological explanation of disease, and open a space in which doctors and patients are mutually affected. This subsection focuses on the ways doctors are affected, are pulled toward and transformed by the demands of the rural vernacular and meaning of disease. The chapter continues with an analysis of the medical affective care practices that remittances demand, and how through this kind of "care" doctors allow for a "forgiving" medical practice, open to second chances and the tinkering of treatments. I turn to the ways that doctors openly give non-clinically needed therapies and demonstrate, on one hand, how financial interests shape therapies, and on the other, how relations with patients reshape "clinical need." The chapter closes with

some speculative thinking on how remittances and families may have transformed the doctor into a charlatan under biomedical standards, but may have simultaneously also transformed the charlatan into a doctor. These transformations call into question, or at least unsettle, the overarching logics that make the doctor and the charlatan opposing categories. In looking at how a doctor/charlatan becomes one and the other at the same time, the complexity of what is to be a doctor in rural El Salvador becomes evident.

3.2 Translating

When Salvadorans say they return to El Salvador to receive care "in their language," they do not only mean Spanish, they mean the local vernacular of El Ocotal. They want a doctor that understands them. When Doctor Cardona first came to work at El Ocotal's public health clinic as a young doctor sent to the rural area in his obligatory year of social service, he found notebooks left behind by another doctor, which contained lists of local words used to describe different body parts and ailments. The nurse, who grew up in the area, told him about how the previous doctor at the end of each day asked her about the words and expressions he did not understand, slowly filling several notebooks in his year of social service at the clinic. Doctor Cardona needed the same kind of help even after studying the notebooks. He grew up in a large city not too far away from this rural town, yet found the differences in the local vernacular large enough to need a translation into his own urban Spanish. Doctor Cardona says there are many words he still does not understand, even though he has been working in this area for over a decade. Most doctors in El Salvador come from the capital, or from the second largest city in the country, like Doctor Cardona.

Doctor Escalante also talks about the difficulty of understanding her patients in her small-town private clinic. She grew up in San Salvador and earned her medical degree in Cuba, and says the work of translation in her clinic is constant, but recalls her lack of understanding of her patients at the beginning almost paralyzing. She had never spent more than a few days in the countryside before she set up her private practice in a small town near El Ocotal. After she came back from Cuba, she could not get a job in the

public health care system in the capital, and eventually decided to try her luck in this small town. Her sister had married a local who helped Doctor Escalante become the on-site physician for a local pharmacy. In time, she set up her own clinic. She tells me that,

> [A]l principio me costaba con los pacientes, [. . .] me decían un vocabulario que no comprendía, entonces tenía yo que utilizar una técnica para llegar a ver qué es lo que el paciente me quería decir. [. . .] [H]ablan de que tienen *dolama en las verijas*, me dicen que tienen una *morición*. [. . .] Yo no sabía qué era un *ajilamiento*. [. . .] [A]hora me parece evidente, pero en su momento no lo comprendía, no comprendía qué era lo que la gente me quería decir.
>
> [In the beginning I had a hard time with patients, [. . .] they used a vocabulary that I did not understand, I had to utilize a technique to be able to see what the patient wanted to tell me. [. . .] They talk of a *dolama en las verijas*, they tell me they have a *morición*. [. . .] I did not know what was an *ajilamiento*. [. . .] Now it seems evident, but in its moment I did not understand, I did not understand what people wanted to tell me.]

Doctors throughout this area are continuously making efforts to understand their patients, and the success of those efforts manifests in the claim that patients return to receive "medicine in their language." The doctors I interview in villages and small towns have different class upbringing, but most are raised and educated in San Salvador. Many come to work in areas like El Ocotal during their obligatory social service year, and decide to stay after falling in love with a local, or decide to return when they do not find employment in the capital after they graduate. In my interviews, I met only one doctor that was raised and went to school in the same rural area he was now servicing; he was the only one that went to medical school with the explicit goal of being a small-town doctor. Most of the language differences that doctors talk about refers to the different names of body parts and expressions to name altered body states that is generally homogenized in formal schooling through the language of elementary-school biology using formal Spanish. The patients that doctors have a hard time understanding either resist or have not been subject to such homogenization. Doctors here are concerned with figuring out which part of the body their patients are referring to, or finding out whether it burns or hurts, or if it flutters or digs. They seem to want to create a dictionary of single-word equivalences in

the fashion of pocket language dictionaries in which they could quickly find that *dolama* is equivalent to *dolor* (pain), *verijas* to *matriz* (womb), and so on.

However, when they refer to what different ailments and treatments may mean to their patients and the subsequent effects such meanings may have in the social organization of their lives, doctors dismiss them as the "myths" they struggle to dispel. Doctor Escalante for example talks about the challenges that culturally held beliefs about biomedical treatments pose to compliance of those treatments,

> [L]a gente tiene muchos miedos. La gente tiene sus ideas propias de que "si me estoy tomando una vitamina, no puedo, no puedo comer limón, porque me va a caer mal," o "si estoy embarazada y me dan hierro, yo no me lo tengo que tomar porque me mancha la cara," o, bueno, existen un sinfín de mitos, ¿verdad? Entonces, es, eso hasta el día de hoy me cuesta, o sea explicarle al paciente y convencerlos, porque el paciente le puede decir "sí, le entiendo, sí," pero al final usted se da cuenta que no ha cumplido las indicaciones.
>
> [People have a lot of fears. People have their own ideas that, "if I'm taking this vitamin, I can't, I can't eat lemon because it will not sit well," or "if I'm pregnant and they give me iron, I don't have to take it because it stains my face" or, well, there are many myths, ¿right? So, until this day I have a hard time with that, I mean, to explain to the patient and convince them, because the patient can tell you "yes, I understand you, yes," but in the end you realize that he/she hasn't complied with the instructions.]

Her main concern seems to be to convince her patients to comply with the treatment, and it is not clear that to do so she feels compelled to explain that she believes that lemons do not cause a problem with vitamins, or to explain the importance of complying with the treatment without such confrontation. The difference is important; in the former she would be trying to convince her patients that they are wrong, in the latter there would be an "accommodation." She later tells me that after coming to know what they mean, "uno mas o menos se adapta y trata de que hablar el lenguaje de ellos" [one more or less adapts and tries to speak their language]. Although Doctor Escalante operates under the belief/knowledge framework, in which her patients' beliefs interfere with the treatment she has prescribed based on her scientific knowledge, there is an important negotiation worthy of further investigation. What allows for this negotiation? How does the struggle

for "simple" equivalences and the simultaneous relegation of local medical practices to myths open the space for an adaptation? And what does this adaptation afford? Doctor Escalante is not using the term "myth" as a social organizing process, a reality making process important in understanding health and illness, but rather as a problem that challenges treatment adherence. Nevertheless, she is affected. To think about what is staged in this being affected, I will delve into what *happens* in the *effort* to find equivalences. My attempt is to look beyond[4] the anthropological critique of the medical behavioral sciences that has made evident the practical and theoretical shortcomings of attempting to educate individuals to modify "irrational" behavior to comply with medical regimes, reduce risk factors, or seek care appropriately (Good 1994, 37–38).

She, nor any of the other doctors I interview in this area or in any other area in El Salvador, including those representing the public healthcare system, talk about culture, cultural competence, cultural sensitivity, cultural empathy, or any of the other term that has entered medical training and best practices in the US to address the challenge cultural myths pose to treatment adherence. But what Doctor Escalante does may be analyzed to demonstrate the shortcoming or the possibilities of cultural competence—the reduction of culture to a specific vernacular for instance, or the possibility of understanding medical realities as the product and process of sociocultural organization. Cultural competence came about in the US in the sixties to precisely address the issue of ethnic minorities and their lamentable low treatment compliance that supposedly results from the kind of cultural myths that Doctor Escalante speaks about (Kleinman 2006; Kirmayer 2012; Willen and Carpenter-Song 2013; Baker and Beagan 2014). Cultural competence frames culture as a language in which one can become fluent. The doctor is asked to be fluent (competent) in the patient's language (culture) in order to translate to his language (medicine). In such a framework patients' understanding and response to their illness is mapped onto biological and physiological referents of medicine, leaving disease to remain a stable reality that pre-exists the naming by medicine, and the naming by patients in El Ocotal (Good 1994). The quality of patient-doctor encounters can be measured in

4. or perhaps look sideways.

terms of the ability of the doctor to decipher the narrative of symptoms as told by the patient, and the expression of disease as told by the body. Within this culture/nature model the mastery of rural illness vernacular makes doctors "better," and assumes that once Salvadoran migrants learn the local language of their new town, be it Los Angeles, New York, or Washington DC, they will no longer need to return to El Salvador in search of the "cultural competent" doctor of their birth town.

But an interpretation of narrative of symptoms, or illness experience of patients as a language to be translated into the language of medicine would affirm the separation between nature and culture in which disease remains a stable reality that pre-exists and is independent from science and from culture. The study of the clinical encounter as a problem of translation between the categorization of reality into different registers has been critiqued through different intellectual traditions concerned with language and with how worlds are made. Byron Good (1994) gives a genealogy of medical anthropology's interventions and offers his own semiotic analysis in which symptoms take meaning relationally within their context, which help constitute illness experience. In analyzing a narrative of symptoms of a patient in a clinical encounter at Harvard Medical School, he concludes that "Symptoms are given meaning within a cultural system relationally, by the position they occupy within complex symbolic codes, and traditional forms of healing may have efficacy through such symbolic codes and the experiences they evoke" (99). The meaning making of symptoms is important because it "provides the sufferer a frame for interacting with the social and physical environment and organizes it as a special form of reality" (100). The social worlds of patients are made through the meaning symptoms take relationally, within the "codes" that govern the lives of patients. The same can be said of medicine's symbols—they acquire their meaning relationally through their own semiotic relations. He goes on to explicate what is required for translation to occur, "translation of concepts [. . .] requires analysis of both semiotics and *practices*, scientific and therapeutic, and the interrelations among these" (emphasis added 113). There is no easy mapping of concepts since there is no fixed external referent to culture that allows for that mapping. Instead, a "comparison of the situated practices through which knowledge is produced

and elaborated" (Good 1994, 112) must take place for translation to occur. The "situated practices" are indeed what produce knowledge, the context that gives meaning to symptoms.

Actor-Network-Theory takes a "ruthless application of *semiotics* [. . .] It takes semiotic insight, that of the relationality of entities, the notion that they are produced in relation and applies this ruthlessly to all materials—and not simply to those that are linguistic" (Law 1999, 2–3). The problem with sticking only with language, and the narrative of symptoms in our case, is that everything that is not language sits outside the dynamics of relationality. The problem, as expressed by Bruno Latour (2004) is that,

> In that model [object-subject model], there is a body, meaning a subject; there is a world, meaning objects; and there is an intermediary, meaning a language, that establishes connections between the world and the subject. If we use this model, we will find it very difficult to render the learning by the body dynamic: the subject is 'in there' as a definite essence, and learning is not essential to its becoming; the world is out there, and affecting others is not essential to its essence. (208).

I speculate that what Salvadorans seek is not only a doctor that understands what *verijas* means, what *verijas* stands for in biology, but one that accepts the kind of body that is made between the doctor and the patient when *verijas* is translated. By this I mean that the practice of translation itself forms part of a materiality of that body that is being translated, and as such, makes a particular body. It is not only the translation of words, but the translation of bodies and practices that occurs. This is the body that this dissertation is trying to sketch, and I can only sketch it here because it is in these clinics that it is actually made.

In trying to take the process of translation as a relation that dynamically makes what is being translated, I see the opening to consider the clinical encounter as a possibility of "learning to be affected" to use Latour's term, or learning to be present, to use mine as explained in the previous chapter. A body emerges in the process of understanding, not in the finally "understood" body in medicine, but in what remains in question which is what stays open for translation over and over again. I am not proposing that this should be the

way doctors should understand the body to practice a better medicine. My point is that in the practice of translation an intimate engagement occurs. The young doctor quoted earlier, Doctor Escalante, says she needs to use a "technique" to understand her patients. She later elaborates that when she did not understand she would ask herself "¿Cómo se manifiesta eso?" [How does that manifest?], and that she, "Tenía que ahondar para llegar a comprender qué era lo que la gente me quería decir realmente." [Had to delve deeper to comprehend what it was people wanted to really tell me]. What she had to do to "delve deeper" is unclear, but this "delving deeper" evokes the sense of digging into, burrowing into understanding. In that extra "depth" that must be traversed to translate what is not understood lies the intimacy of the relation. This doctor works to "delve," to "reach inside," to literally "excavate" or "dig into" what is not understood. In the work required to "deepen" the understanding, the doctor gets closer, comes closer to the patient. That intimacy, that shortening, that borrowing makes the medical encounter.

This "excavation" or "digging deeper" can be construed to be the process of recognition—the arduous effort to be "apprehended" by the knowledge system of the doctor. Such a process requires the stabilization of the codes of the patient, at least to the extent that the doctor can identify what they mean in medicine. But I don't mean this "going deeper" to be the extra effort to find meaning (as in semiotic translation), but rather the becoming of bodies into one another, making a different kind of intimacy. What I want to transmit is the sense of frustration in the translation that requires a further approach, a reaching, which remains persistent.

In contrast to Doctor Escalante's efforts to "delve deeper," Doctor Cardona has a degree of acceptance of incommensurability. He admits to not understanding and lets it be. He listens and tries to integrate non-compliance into his treatment, which means he does not try to contradict his patients about what causes disease, the names of symptoms, or the significance of therapies. In the end doctors translate with caution, perhaps hesitantly, not because they have understood, but because they respond to patients' sensibilities. In the hesitance to translate *and* in the unavoidable necessity to translate, the doctor and the patient are made over and over again, every time made anew.

Both these doctors talk about the need to not contradict patients and to use the patient's language. The young doctor offers that "uno habla igual al paciente, porque sino, no hay manera de establecer una comunicación, que el paciente se sienta completo" [one has to talk like the patient, otherwise there is no way to establish communication, for the patient to feel whole]. Although both these doctors express the sense that the burden of translation is on them, Doctor Escalante mentions that, "el paciente se acomoda" [the patient accommodates], and "uno más o menos se adapta" [one more or less adapts]. This "accommodation" and "adaptation" undertaken by patients and doctors makes bodies dynamic, open to being affected by each other, susceptible to becoming with each other.

I find interesting that Doctor Escalante did not offer a translation of the local terms she was using until I asked her to explain what those terms meant. When reflecting on those terms she later says that "[A]hora me parece evidente" [today it seems obvious], as if the terms had always existed in-and-of-themselves, or as if the reality they make was always evident. It's difficult to speculate what she may mean by stating that the local vernacular for symptoms is obvious, clear, evident. They are clearly what? What do they make evident? Her statement seems to offer an opening for symptoms to create a reality of their own that is self-evident, that *is*. Nevertheless, she goes back to "adaptation" and "accommodation" as if to acknowledge the frictions and dynamics that make them "evident." Perhaps this "reaching into each other" of translation is what Salvadorans seek, presumably a kind of presence not found in the US when translation is not even attempted.

3.3 Affecting Care

Medical anthropology literature has paid close attention to different organizing logics that condition medical travel—from laws that inadvertently remake "biological relatedness" necessary for organ transplant in India (Cohen 2011), to the way faith configures "pilgrimages" for experimental stem cell therapies (Song 2010), to how globalization and the allure of reputation mobilizes Yemenis to search for therapies abroad (Kangas 2002). But feelings and sentiments have only seldom been studied as organizing categories. Har-

ris Solomon (2011) addresses emotions and sentiments directly in an article that "examines the grid of sentiment that structures the relations between nations, bodies, and forms of care produced through medical travel to India" (106). The analytics of sentiments—as these pull and push subjects across geographic borders, through healthcare's failures and promises, and into relations with caregivers far from home (107)—offers a logic of networks based on social sensibilities connected to geopolitical and economic governing. Solomon's intervention presents a contrast to studies that render emotion as ancillary to health services. His argument is not only that sentiments are present, but that travel itself is articulated through affective discourse.

Affect taken to be the "capacities to act and be acted upon, [...] as those forces [...] that can serve to drive us toward movement, toward thought and extension" (Gregg and Seigworth 2010, 1), can be a concept useful to make sense of traveling bodies. It lends itself to think about the ways sentiments of betrayal, gratitude, or risk for instance, have the capacity to move bodies and organize travel across destinations. Through the conceptualization of affect by Kathleen Stewart (2007), Solomon proposes that "The sentiments instantiated through medical tourism exemplify this pull and push of subjects: across geographic borders, through healthcare's apparent dead-ends of solemn resignation and promising, unexpected detours, and into relations with caregivers far from home" (Solomon 2011, 107). The rural clinical practices characterized by the sensibilities of touch and warmth described earlier seem to similarly organize travel in El Salvador—doctors say patients travel precisely to seek this kind of care. But traveling—moving from one geographic, cultural, social space to another—is not the only action that Salvadorans take. Doctors in rural areas engage in kindness, empathy, and tenderness with the explicit intention to provoke an emotional response that affects patients as well as their own practices. They elicit positive emotional responses from their patients with the hopes of assuaging their pain and suffering, and with the hope these will allow them some leeway in the certainty of their diagnosis. I call this kind of care "affecting care" to highlight its explicit expectation to affect both patients as well as doctors, and to distinguish it from the care not expected to produce affects and have effects, one that is not done intentionally to

bring one another into relation, and therefore into being. The grammatical double use of "affecting" (as an adjective and a verb), gives "care" the quality to affect people and things, and it is meant to invoke unsaid actors affecting the practice of care (such as remittances and travel). In this sense "affecting care" operates as a way for doctors and health workers to activate the "bodily capacity to affect and be affected or the augmentation [...] of a body's capacity to act, to engage, and to connect, such that autoaffection is linked to the self-feeling of being alive" (Clough 2007, 2). "Affecting care" can be thought as the force, shuttling intensity, state, or event that forms the capacity of things to become with another (Gregg and Seigworth 2010). The warmth so often mentioned among remittance clinic doctors seems to organize travel to private care in rural areas in El Salvador while simultaneously soothing comfort makes doctor and patient become with one another.

In El Salvador the oft-quoted phrase "servicio con calidad y calidez" [services with quality and warmth] amounts to a slogan, seen on almost every single official document released by health government institutions of both conservative and liberal presidential administrations in the past decades. On one hand, the political movement that introduced quality control measures promoted *calidez* in service as an element of user satisfaction (see Programa de Garantía de Calidad de Servicios 2005). "User satisfaction" was made a measurement of improvement of medicine to articulate a supposed user discontentment of public health, and thereby propose its privatization. Interestingly, the 2007 National Healthcare System Law, passed under the administration of conservative president Antonio Saca 2004-2009,[5] pronounces the constitutional guarantee to healthcare access as a right with the characteristic of *calidez*.[6] In the context of "user satisfaction" and the

5. But which emerges at the intersection of international calls for reforms by the PAHO, national political interests to increase the privatization, and grassroots mobilizations against privatization through a series of multi-month strikes in 2005-2006.

6. Art 3. El Sistema Nacional de Salud tendrá como meta el cumplimiento de la garantía constitucional de acceso a los servicios de salud, como un derecho social de todos los habitantes del territorio y tendrá como características distintivas el humanismo, respeto al usuario, ética, calidez, universalidad, equidad, solidaridad, subsidiaridad, accesibilidad, calidad, integralidad, eficacia, eficiencia, oportunidad y participación social. [The National Healthcare System will have the goal to meet the constitutional guarantee of access to healthcare services, as a social right to all the inhabitants of the territory and will have the distinctive characteristics of humanism, respect to the user, ethics, warmth, universality, equity, solidarity, subsidiarity, accessibility, quality, integrity, efficacy, efficiency, opportunity, and social participation.] (GOES 2007)

intent to guarantee the right to health through private concessions prior to 2007, *calidez* seems to have the capacity to transform medicine from therapy to service—medical professionals delivering painful and unpleasant procedures may be disqualified for not being "warm" enough. On the other hand, the subsequent left-leaning administrations have linked *calidez* and user satisfaction as a form of social participation, which has been one of the main themes of the 2009 Health Reform. Perhaps the emphasis that all parties have given to *calidez* only highlights its traditional absence in public medicine, and that what you buy in private care is precisely *calidez.*

Many of the patients I interview in the rural areas do talk about the private clinics they visit in emotional, or affective terms. They juxtapose the "warm," "personal," "touching" care they receive in private clinics, to the ways they feel they are just "a number," without a name in public ones. Similarly, Doctor Jimenez thinks Salvadorans coming from abroad seek "empathy," which they cannot get in the "high-tech" medicine of the US. He says,

> Aunque la tecnología la tengan, pero lo que sucede es, es, yo creo que es la cuestión empática, ve'a. Porque aquí la gente le gusta que usted lo *chinchonee*; si está con el dolor, "ya mamita, ya va'estar, tranquila, le vamos a poner este voladito oye, tranquila, tranquila, vaya ya estuvo." Allá no, que le duele el estómago, "Hacele el TAC, me voy y me llamás," y sale. Entonces, tal vez el contacto. Acuérdese que carentes de afecto, que les hace falta la nana, el tata, y les hace falta los hijos allá y que el doctor tampoco le de un poquito de atención, sin preguntarles "¿Cómo se ha sentido, se ha tomado la medicina, y cómo va esa dieta? La veo más bonita, hoy está un poco más gordita." O algo así. "Ey el doctor, el doctor se fijó en mí." O si quiera una bromita, o un "Estoy a la orden oye, cuídese oye." Cositas así creo yo que hace la diferencia.
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> [Even though they have technology, but what happens is, is, I think is the issue of empathy, right? Because here people like that you *chinchonee* them; if they are in pain, "it's ok *mamita*, it's almost over, relax, we are going to put this thingy, relax, relax, alright it's over." Over there no, that your stomach hurts, "Do a TAC,[7] I'm leaving, call me," and you're gone. Then, maybe it's the contact. Remember that lacking affection, that they are missing their mama, their papa, and are missing their children over there and that the doctor also does not give them a little bit of attention, without asking them "How have you been feeling, have you been taking your medicine, and how is that diet going? I see you more beautiful, today you're a little bit fatter." Or something

7. Tomografía Axial Computarizada, what is known in the US as CT Scan.

> like that. "Eh, the doctor, the doctor paid attention to me." Or even a little joke, or a "I'm at your service, take care." Little things like that I think make the difference.]

In this description, the kind of affect in care Salvadorans seek is juxtaposed against technology, and requires the diminutives and intonations of the difficult-to-translate local vernacular. Doctors are expected to *chinchoniar* patients, a local variant of *chinchiniar*, which in standard Spanish means *consentir, mimar* (to indulge, spoil, pamper, or coddle). Its root is the onomatopoeia *chinchín* (a baby's rattle), a noisemaker to distract and sooth a crying baby.[8] But the word may also be associated with *chiniar* (to hold a baby in your arms). Here it functions as a combination of the two—Salvadorans return for the *chinchín* given by doctors, their special ability to sooth the crying patient, to make her relax and be comfortable, and for the doctor's capacity to *chiniar*, to hold patients in their arms. Accompanying the "relax, relax" of Doctor Jimenez, you can almost hear the "ts-ts, ts-ts" of the *chinchín.* On a first instance, according to Doctor Jimenez, Salvadorans seek a delivery of care characterized by feelings of comfort, indulgence, and pampering that alleviate suffering in ways that technology cannot.[9]

On further analysis, Salvadorans seek care that soothes their pain in more ways than one. Doctor Jimenez is explicit about the different kinds of pains that rural private medicine soothes: the painful insertion of a "thingy" and the painful "lack of affection" from physically absent relatives. Here medicine also soothes the pain of migration and separation. Furthermore, patients seek "attention" in the sense of "to take care" and "to take notice." They seek doctors that "take care" by "taking notice"— by noticing changes ("I see you a little bit fatter"), asking about those changes ("How is the diet going?"). Taking notice as a form of care requires an opening up of bodies, a willingness to become with one another. The "noticing" cannot be "done" to the other, the other needs to notice being noticed for "noticing" to happen. It is performed to affect—to make the other say

8. See Meza (2008) for definitions of Salvadoran vernacular.

9. Mol (2008) suggests that this easy opposition between care and technology forecloses the capacity that technology has of participating in caring practices that improve health. The shift requires a reconsideration of what care means; the care Salvadoran doctors work toward is explicitly filled with emotions and affection as explained defined above.

"Eh, the doctor paid attention to me!" In that practice, patient and doctor make each other.

Patients are not the only ones that desire ways to be soothed, held, and cared for in order to "heal" their negated subjectivity (negated not only through the lack of physical affection from far away relatives, but through the impossibility of being this kind of patient in the US). The doctor also desires to be "grand,"

> La gente en el fondo yo creo que la gente anda buscando afecto [. . .] y entonces el médico tiene que darle un poquitito de afecto, y entonces *usted va a ser grande, usted a ser bueno.* Y a pesar de que de repente usted se equivoque en un diagnóstico, se equivoque en un manejo, pero a ella no le importa, a ella le importa que usted fue muy bueno con ella y la atendió, y la. . . ve'a.
>
> [People in the end I think people are looking for affection [. . .] and then the doctor has to give them a little bit of affection, and then *you will be grand, you will be good.* And even though all of a sudden you may be wrong about a diagnosis, may be wrong about a medical management, but to her it does not matter, to her what matters is that you were good, and that you looked after her, and that. . . right?]

"Affecting care" is given not as a selfless act, but as a selfish one—it is offered in the interest of the doctor to be "grand" and "good." The doctor gives "affecting care" to get something in return: impunity. This grim exchange reveals the unethical dark potential of "affecting care." But it need not be read this way. What is interesting is not on the "grandness" of the doctor, but the transformation of the medical space. When there is "affecting care," no longer is the priority the science of medicine, but instead the *chinchineo* of people. "Affecting care" allows the doctor to make a medical mistake and be forgiven, effectively transforming a clinical interaction into something that is more than only scientific knowledge. I am tempted by oppositions, if you have not already noticed, and my first impulse is to say that the clinical encounter is no longer clinical, but social. But here I think it makes more sense to say that "affecting care" moves into the clinical space to share the space with science. If "medicine" makes a mistake, there comes "affecting care" to let it have another chance. But even this opposition begs to be undone, what the "affecting care" to "medical mistakes" exchange makes evident is that in these

clinics medicine does not operate without "affecting care," rather than an opposition a collaboration and co-existence, perhaps even a making of each other, makes more sense.

3.4 Treating with *Sueros*

In *Differences in Medicine* (1998), Marc Berg and Annemarie Mol undo the humanist idea that medicine is a coherent discipline that knows the universal biological body, and suggest medicine is the result of the negotiation of local practices in tension and contradiction. They attend to the complexities of "differences in medicine" in contrast to offering overall explanatory models of bodies, disease, diagnosis, treatments, etc. Two of the practices through which biomedical reality is being made in the rural clinics of El Salvador are translations and affections. In the translations of the local vernacular of illness experience, and the tensions between desiring to be good doctors and expecting to be soothed patients, bodies are diagnosed, treated, and examined. In what follows I further explore ways in which local practices make particular doctors and patients.

Patients often come to these rural clinics in search of *sueros* (normal saline solution[10] sometimes with added vitamins or iron, administered intravenously). People ask for them in pharmacies and private clinics alike. Some doctors refuse to give *terapia intravenosa* (intravenous therapy), as it's medically termed, when it's not clinically needed, arguing that it's unethical to do so. Others argue it does no harm, and give them if the patient does not present issues for which *sueros* are contraindicated. Doctor Boris has one of the busiest clinics, and often by the time I arrive, usually mid-morning, there are two to three patients receiving IV drips. His clinic is the best equipped of all the clinics I visit, perhaps because it's in a town not quite as rural and far away from a large city as Doctor Cardona's. In the small rented house, two hospital transport beds (stretchers on wheels) furnish the "therapy room," in which small surgeries and respiratory therapies take place. But when both beds are occupied, respiratory therapies or IV therapies must be given in the waiting room. There is a computer-printed sign that hangs on the wall next to the front desk that reads,

10. Also termed *suero fisiólogico*, usually 0.9% sodium chloride solution.

Figure 3.1. Special chair for receiving *sueros* (center) in Doctor Cardona's clinic. Eastern El Salvador. 2012.

Suero vitaminado [IV with vitamins] $15
Suero con hierro [IV with iron] $30
Citología [Vaginal cytology] $9

The prices[11] are typical of the area, but no other clinic I visit has the extra room with beds where patients can rest. Usually there is a designated "IV drip chair" that is more comfortable than others, such as the plastic cord lounge chair in the terrace of Doctor Cardona's clinic (Figure 3.1). But in Doctor Escalante's clinic, patients can only sit on plain plastic chairs to receive their drips, which hang from a nail on the wall (Figure 3.2).

What I find most interesting about *sueros* is that doctors quite candidly tell me that they administer them even when the patient does not present a condition they are clinically required for. For example, *sueros* with iron are recommended for anemic patients that may take a long time to absorb iron orally and must take it intravenously. Yet, they administer them even when those conditions are not met—they administer them upon request. Doctor Escalante, the young doctor quoted earlier, explains that patients

11. Printed in US dollars (economy dollarized since 2001). As a reference 2012 minimum wage for agricultural workers (lowest of all) was $115.50 per month (Ministerio de Trabajo y Prevención Social http://www.mtps.gob.sv).

Figure 3.2. Empty *suero* bags hanging from nails after being administered to patients. Patients sit down on plastic chairs for about 20 minutes to receive their *sueros*. Eastern El Salvador. 2012.

auto-diagnose themselves often, and then don't always come for a medical consultation. Instead, they come already prescribing their own therapy, with blood work or even ultrasound exams already done without being prescribed by a professional.

> [M]uchas veces está el inconveniente que el paciente, claro, él supuso que eso se tenía que hacer, en el laboratorio le dijeron que a lo mejor eso era, pero resulta que al examinarlo yo quiero otros exámenes, entonces tiene que volver a pincharse [. . .] son cosas que uno aquí tiene que manejar, porque aquí el paciente solito se receta los exámenes, sabe qué exámenes necesita.
>
> [Many times there is the inconvenience that the patient, well, he assumed that that was what he had to do, in the lab they told him that he was probably right, but it turns out that after examining him I want other exams, then he has to prick himself again [. . .] these are things that one here has to manage, because here the patient auto-prescribes by himself, he knows what exams he needs.]

Using a recent request for a vitamin ampoule injection as an example, she says the patient did not want even to have her blood pressure taken, she just wanted the injection

administered. Doctor Escalante is from San Salvador, and says she had never heard of people auto-prescribing *sueros* until she came here; she thinks it's a particular practice of the eastern part of the country. When I ask her to elaborate, she offers an interesting explanation of the demand that bypasses the recommendation of medical professionals for vitamins and *sueros*, injections and IVs, which situates the practice in history, marketing, and patient-doctor relations. I haven't done any research on the history and marketing that makes this practice possible,[12] but let me elaborate on the ways the practice of *sueros* makes particular patient-doctor interactions by delving into what the practice does.

Doctor Escalante talks at length about the requests she receives from patients, all the while indicating that she acquiesces to the requests, carefully not contradicting patients while at the same time trying to "explain and convince" her patients about treatments and their instructions. Even though she insists that patient education is one of her jobs, by which she means undoing the "myths" they have about their bodies and illnesses, she is one of the doctors that was most preoccupied by wanting to understand her patients without contradicting them. She says that in the perpetuation of the cycle of demand of patients and delivery of doctors of *sueros* and vitamins, there is a patient saying "Y la doctora es mala porque no me dejó vitaminas" [And the doctor is bad because she did not prescribe vitamins], and a doctor wanting to be "good." Even though the patient may not need any vitamins, or something else, she nonetheless prescribes. Vitamins may be innocuous, but I find the exchange important in trying to make sense of medicine here. Doctors want to be "good" and so they respond to patient's requests. This can be simply interpreted as a mercantile exchange—doctors self-interested response to the individual requests of consumer patients, or worse, the entrepreneurial citizen patient invested in care of the self. But I want to take the exchange seriously, let me speculate on what the materiality of the exchange does in terms of creating a medicine.

What emerges in the tension between not contradicting the patient while at the same time dispelling their "myths?" There seems to be a compromise on the part of the doctor. It is she who, in the end, thinks that local expressions of disease are "evident" and notions

12. For a study on the marketing of packaged pharmaceuticals and their delivery by non-medical professionals see Ferguson (1981).

of body, and expressions of pain never really needed translation. I speculate the clarity Doctor Escalante has about the expressions of suffering of her patients does not only refer to a successful translation into medical language, but also refer to the clarity of what a body *is* in her becoming with her patient. The exchange is between not only the doctor and the patient. But these exchanges are made possible through the remittances of relatives that also transmit their aspirations of wellbeing in the delivery of those remittances. And wellbeing is the ability to go to the pharmacy or the doctor to request a *suero*, to be able to demand it. *Sueros* may be particular to this area historically, but they are also part of the social bonds created through remittances. Furthermore, notions of bodies, symptoms, and treatments traditionally outside of medicine come to *exist* in tension and contradiction with the medicine of the doctors. They exist, they are not dismissed or negated. Rather than being kicked out, the patient along with her "myths" and demands is folded in, not out of some respect for the difference of the other, but out of personal interests to be "good." These are not bodies (doctors and patients) that are free to do whatever they want, they have multiple attachments to many others that oblige them to compromise on their own notions of disease, and self. The mercantile exchange is not simply an exchange of unattached individuals that choose to either sell or buy something, but it is the effect of social bonds being remade in the exchange.

It seems this medicine that arises in contradiction, in self-interests enabled by remittances, in affections demanded by the lacks of migration, in translations requiring a borrowing into the other, has a hard time traveling. The bodies that open up to be affected do so in conditions enabled by intimate encounters requiring a particular history and coming together of events. The biomedical reality that is produced is anchored in each exchange, each translation, each interaction. Patients come here in search of biomedical realities that make their bodies able to act and be acted upon, to meaningfully engage with their medical world, to be present, to be.

3.5 The Doctor and the Charlatan

To conclude that the fulfilled request for clinically unnecessary treatments is only a corruption of medicine, surely the work of charlatans and self-interested doctors, would be to accept the only notion of biomedicine possible is one that negates disease could reside outside the "body proper," and performativity and enactment of procedures themselves could contribute to cure and healing. This section explores how the doctor-patient encounters in El Ocotal help us think of a notion of biomedicine that includes its own foundational opposite—"irrational cures," in order to reconsider, counter-intuitively, how a remittance economy might make a different medicine that ends up in constant friction with biomedical, biopolitical, and biocapital projects. Inspired by Isabelle Stengers's "The Doctor and the Charlatan" (2003), I attempt to reconsider how the clinic is a space that attends symptoms that are not welded[13] to the body, but neither are they the stuff of magic and sorcery.

Stengers (2003) opens her discussion into the making of modern medicine by reviewing the 18th century invention of a method to test the therapeutic powers of doctor Franz Anton Mesmer's magnetic fluid treatment. The method, a "clever trick" as Stengers later notes, involves either magnetizing a "likely subject" without his knowledge, pretending to magnetize him, or blindfolding him to make him believe one part of his body was magnetized, while in reality another one was. The commission evaluating the curative powers of the magnetic fluid concludes that, "the fluid is powerless without imagination, while the imagination without the fluid is able to produce the effects that are attributed to the fluid" (14). In other words, the fluid did not pass the test—it proved to cure, but for the "wrong reasons," as Stengers puts it. The test, meant to determine if the magnetic fluid is a causal factor for the cure, also makes evident that the body can be cured by imagination! In a surprising reading of the event, Stengers suggests that, "cure proves nothing," medicine is not interested in cures in general, but rather in cures for the "right reasons." She sets up the medical doctor in opposition to the charlatan, who "is henceforth defined as he who puts forward his cures as proofs" (15). Swiftly, Stengers

13. Tobie Nathan's term through Stengers (2003, 32–33).

exposes medicine's profound contradiction—its inability to get rid of the irrational object that determines its own rationality; the doctor officially needs the charlatan to create itself, medical treatments need the "placebo effect" to legitimize themselves through their negation.

Furthermore, the capacity to be cured by imagination demonstrates the suffering body is unable to make a distinction between a scientific fact (the fluid) and fiction (the trust in the fluid), making it an "unreliable witness," in the words of Stengers. The commission sets up the "blindfolding" test to make a reliable witness out of the body, but the test faces an insurmountable challenge in attempting to distinguish between these two objects, as "trust in the fluid," "imagination," or "the power of suggestion" cannot be submitted to the initiative of the experimentation (Stengers 2003, 24). "Imagination" always has the potential to take its own initiative and intervene in the cause of cure. The problem is in the experimenter's inability to "control" one of the objects needed ("imagination") to determine the other ("treatment"). In the binary set by the 18th century commission, there were only two possibilities of cause—imagination and fluid—and Stengers asks why not consider other causes, such as touch. Today touch has risen to be a legitimate treatment demonstrating positive statistical difference against placebos (on chemotherapy and touch see Linden 2015), and other therapies such as chiropractic, acupuncture, massage, meditation, and even craniosacral biodynamics are filling the list of non-drug therapies that are passing the placebo test. The "placebo effect" remains the event against which medicine is legitimized, and everything from surgeries, to drugs, to touch has to be proven to be better than the imagination to be considered "medicine." One of Stengers' points is to note how the modern charlatan, a figure that includes healers and all those that put their cures as their proofs, is set to be the opposite of rational medicine, which is concerned not with curing, but with separating "placebo effect" from "scientific treatment"—a process that needs a test to try to make the body speak, which ultimately is fraught with frustration as it can never make the body attest which was the cause of its cure.

Mesmer was made to be a charlatan through the failure of the magnetic fluid to be the cause of the effects attributed to it, which first required that the fluid be a testable object,

in the words of Stengers, “a ‘cause’ capable of imposing its own existence on the basis of the examination of its effects” (Stengers 2003, 15). She highlights how the charlatan makes use of a model of scientific proof too—he claims the cure is the proof of the therapy. For the charlatan the cure is the proof, for the doctor the ability to distinguish causes is the proof. Doctor and charlatan are both caught in their own logics of proof. The doctors in the rural clinics I’ve presented are certified biomedical doctors, registered with national boards, trained to make the distinction between biomedical valid and invalid causes of cure. Yet they prescribe hospitalizations, surgeries, or *sueros*, which, in their own words, are not clinically needed, thereby acknowledging their excess while at the same time their ability to improve the wellbeing of their patients. They straddle the line that separates the cure resulting from placebo from the cure proving to be better than placebo, teetering toward one side by their attachments to patients and remittances, and toward the other by their attachments to medical knowledge and standardized practices. They balance between violating protocols to ensure the wellbeing of their patients and their oath to do no harm. These biomedical doctors as they prescribe treatments they acknowledge to be no better than sugar water, become charlatans as defined by unforgiving belief/knowledge, placebo/science frameworks. Although doctors engage such practices with some trepidation, patients do not see a problem. They want cures, and do not seem concerned with the cause of the cures as long as they cure in the end.

But Salvadoran patients in general, and those in rural clinics in particular spend a great deal of time talking about and determining which doctors are trustworthy, which lie, charge too much, diagnose incorrectly, or diagnose for diseases that do not exist. Extortion of remittance receiving Salvadorans occupies the daily headlines on news outlets and remains one of the top preoccupations in the country. Talking about remittances with doctors and patients proved to be a touchy subject, as no one wants to disclose they receive remittances for fear of being ripped off by unscrupulous doctors or simply robbed in plain daylight. But what is a legitimate disease and treatment gets muddled in a landscape where being sick and going to the doctor has the power to activate an entire network into action including remittances, doctors, diagnosis, relatives, not just the cells of one

patient. Body ailments and treatments escape the possibility of being easily apprehended when disease, treatment, and cure seems to be in excess of single bodies. Let me play a bit more with the ways that charlatans become doctors, and doctors become charlatans to explore the shortcoming of the categories.

Rethinking Cure and Treatment

I return here to the story Doctor Jimenez tells me about the woman who wants to be admitted to the hospital and his own reluctance to do approve her admission. Rather than dismissing the woman who demands to be admitted to the hospital as a patient exhibiting symptoms of neurosis—the psychological condition Doctor Jimenez diagnoses, and rather than dismissing Doctor Jimenez as a self-interested doctor that hospitalizes her without clinical need, let me consider her pain within a different framework of disease and cure. Medical spaces within the remittance economies of rural El Salvador have special capacities to make others act, and as such, they are interpellated by the woman to make her relatives act and *be with her.* The medical space is sought because it forces doctors and relatives to act on her, and in this way bring her into relation with them. In that relation, she exists, or more accurately, she becomes present. The medical space is able to affect relatives and this ability to affect them is what the woman seeks. I'm proposing to think of medicine here as a repairer of family bonds, precarious bonds that have been strained by migration and long-term distance. I'm suggesting that "disease" is the precariousness of family relations, the "treatment" is the medical space as an institution that has the capacity to make relatives act. The "cure" is the affected relatives, the relatives in re-action.

What does it mean to say that the "treatment" is an institution that has the capacity to cause an effect, but an effect not on the body of the suffering patient, rather an effect on the relatives? We are faced with a terrible challenge if we want to claim a biomedical legitimacy because the object is asked to cause an effect, or the object the woman asks to cause an effect, cannot be put to the test in the same way a pharmaceutical, or a therapy can. We cannot even make it into a scientific artefact—an eligible candidate to be tested. It's not even representable. How do we count medicine's ability to repair relations? We

may be able to measure the repair of the social bond, for example by counting the calls, visits, and remittances as representations of what may constitute social bonds. But how do we isolate medicine as a "force" that instantiates those actions to make it into a testable object? Here medicine stands as an actant, a force that enables others to act, but as that force that instantiates capacities, it is hard to measure and be made into a testable object that can produce evidence.

To interpret the "disease" to be the precariousness of family and social relations that threatens the existence of this woman, which is so painful that makes her pull the doctor by his collar to beg him to please admit her to the hospital, offers something different than to interpret it as a psychological condition that resides in the experience of the woman. I'm not suggesting that the social relation is separate from the experience of that relation, that the relation somehow is an entity that exists by itself. In terms of treatment and its effects, there is a difference between on one hand, looking to change the experience of family loss and separation by making changes to the body that has that experience, and on the other, trying to affect other bodies that are in contact with the patient. In admitting the patient to the hospital, who is treated is not the patient, but the relatives. In "treating" the relatives, what is hoped for are affected bodies that carry an imprint of the body that acted upon them. That imprint, the response, the effect of the woman's action, proves her existence. For the social relation, and those re-actions that make that relation, to be the object of interest and not the experience of that relation, situates the disease outside the body and mind of the patient. It's not outside the body in the sense of symptoms being caused by magic or sorcery however—it's outside the body in the sense of being in the relations that constitute her. Here I'm speculating on the idea that bodily dysfunction is also the dysfunction of relations. That bodies are social of course is not something new, and neither is the idea that disease ruptures social bonds (Kleinman 1973). Here it is not disease that ruptures social bonds, but that the rupture of social bonds cause disease, and that the institution of medicine is the extreme space that mobilizes relatives.

That the disease resides outside the body of the individual, and in the relations that

constitute it, seems to be part of the priorities set by the "body dispersed" of rural El Salvador. Medical bodies in El Salvador are made through multiple proxies, through which symptoms, diagnosis, and treatments are enacted. It is not enough for doctors to listen to the narratives of symptoms spoken by the sufferer, to auscultate her body, to measure leucocytes, to see an x-ray. Medical representation and medication are not enough. Doctors must engage the body of the patient as it is made through all her relations, through those that speak for her, that stand in her place, that care for her, that make her present. When those proxies disappear, the body is in crisis. I speculate this is the body in crisis that comes into the hospital.

This proxied body in crisis, and the force asked to affect them may never be able to be put through the test of a scientific model to prove its therapeutic value. The proxies that make this body become excesses within biomedicine, as well as the force that tries to bring them closer. Unable to enter as legitimate practices in the clinic of the doctor set against placebos, nor the clinic of the doctor that embraces placebos, these practices that treat relations as inseparable parts of bodies, become excesses.

Examinations as Treatments

When Doctor Cardona's patients ask him "¿Y no me va a alumbrar?" [Aren't you going to illuminate me?], he proceeds to medically examine them, and starts by asking them to sit on the examination table. He goes through all the motions of a general examination, making sure he auscultates the hearts and lungs with the stethoscope, looks into the fundus of the eye through his ophthalmoscope, checks the ear canal with his otoscope. He finally palpates as necessary. He is not examining for diagnosis he admits, he already knows what they have, he is responding to their request to be a doctor. Patients tell me that they come to these clinics because here they are touched, as opposed to being just nameless untouched patients in the public clinic. Touching has its own power here.

Biomedicine recognizes that the practices of medicine, the procedures themselves, affect bodies in many ways and may even cure. These unintended effects are of great concern when trying to distinguish causes of cures. Unsurprisingly, the performance of surgeries has been suspect of intervening in cures. In one placebo-controlled trial to evaluate the

efficacy of arthroscopy for osteoarthritis of the knee, in which the control group was set to receive a placebo surgery (skin incisions and simulated débridement without insertion of the arthroscope), the authors found that “the outcomes after arthroscopic lavage or arthroscopic débridement were no better than those after a placebo procedure” (Moseley et al. 2002, 81). What I find interesting is not the failure of the surgery to become a legitimate therapy, but the performance of the surgery to have equivalent therapeutic value as the actual surgery. Doctor Cardona knows this, and he recognizes the power that his examination performance may carry in the overall wellbeing of his patient. When he acquiesces to touch the patient, he is not only doing it because he wants to be a good doctor, but because he recognizes that his performance has its own power. Touch as a therapeutic technique has its own history. Today neuroscience has given us “proof” that touch has its own healing power (Linden 2015), and is giving new legitimacy to massage therapy, premature baby kangaroo method, hand holding for chemotherapy, for instance. But the kind of non-diagnostic examination that Doctor Cardona performs suffers from a difficulty that none of these examples suffers from: it does not lend itself to becoming a candidate for testing.

The therapeutic effect of non-diagnostic examinations comes through its ability to bring the patient and the social person into being. The examination itself performs the therapeutic effect. What is causing an effect is the performance of the examination, the sitting on the table, the auscultation, the palpation, the visual examination. Not the diagnosis, but the performance of the examination in which the doctor gets to be a good doctor and the patient a good patient is what makes people feel better. Doctor Cardona values non-diagnostic examinations even when he acknowledges there is no clinical criteria for doing them. But this kind of non-diagnostic touch does not enjoy the possibility to become a candidate for passing the placebo test the way the knee surgery or hand holding during chemotherapy have been made into objects that can be tested. In other words, the apparatus that can make Doctor Cardona’s non-therapeutic touch into a testable object to become a certified therapy may be far away from Doctor Cadorna’s medical world. But Doctor Cardona is not looking for this apparatus. He embraces a form of

medicine for which he does not need the scientific proof of touch, he *knows* its value in practice. Perhaps there is already a double-blind study that has demonstrated the health improvement against placebos that non-diagnostic touch may have—I imagine the test setup may not be very different from the trial to test the effects of touch when nurses hold the hands of chemotherapy patients. But my point is that no such test exists or is desired here—doctors and patients in El Ocotal do not dismiss non-diagnostic touch because they cannot put it through the test. In fact patients embrace it, ask for it, search for it, pay for it, and heal from it. For Doctor Cadorna and Doctor Jimenez who acknowledge to practicing medicine disregarding clinical criteria, they live knowing there is a test that creates clinical criteria and knowing they can live without even if they feel troubled.

3.6 Conclusion

In my discussion of the doctor and the charlatan, when I say that disease is the breakdown of family relations and cure is the repair of these relations, I do not mean to speak to how disease is constituted socially. I wanted to toy with the framework that determines disease and cure rationally, not to demonstrate its limits, although that may have been achieved, but to demonstrate that it is an epistemic framework in which disease and cure can be known through a test. My redefinition of disease and cure means to contrast the rest of the chapter that considers disease not through what they could mean socially, but what they are in practice. I have not intended to write a critique of modern medicine, or a demand for the creation of categories of disease and cure that *another* kind of test could determine. Rather it is meant to be an exercise that puts into perspective what it means to talk about disease in terms of practices and action, in the ways they are enacted and performed. I do not mean to suggest that what Salvadorans are *really*, in fact, suffering from, what they are *really* sick with, is the breakdown of family relations. My contribution is not a corrective to the process of diagnosis. I am not suggesting that the patient needs to be listened to in order to arrive at a better, more accurate diagnosis. I wanted to speculate on how medical practices enact a whole lot of things, including the medicine itself.

Chapter 4

Medical Tourism for Salvadorans Abroad

Abstract. The study of medical travel in medical anthropology literature has focused on understanding why people move across great distances in search of health in a variety of contexts, from pilgrimages to healing waters and distant healers, to vacationing as a form of therapy, to the search for high-tech experimental procedures unapproved at home. Increasingly, the attention has turned to patients moving globally in search of therapies that are otherwise unavailable due to cost, scarcity of biomaterials, or prohibitive legal frameworks for instance—a movement enabled by the reconfiguration of capital, technology and labor, characteristic of the end of the millennium. The medical markets through which Salvadoran migrants and their relatives in El Salvador circulate are not only drawn by shifts in global geopolitical and economic relationships of extraction and dependency, but also by the complexity of the processes that make families transnationally. Some Salvadorans return to El Salvador in search of healthcare to clinics sustained by the remittances they send to care for their relatives, which engender medical practices that cannot be separated from the complex process of making families across political borders, long periods of separation, and uncertain futures. Medical practices in these remittance clinics, as I call them, emerge out of particular conditions of possibility remittances create and are enmeshed in migrant and remittance medical networks articulated as much by the global medical flows of late capitalism, as by the coming together of patients, relatives,

and doctors through rural medical practices. This chapter explores the conditions that characterize these "remittances clinics" within narratives of transnational medical markets, and the ways their very condition troubles their complete absorption into corporate and state economic development projects. I look at the difficulties in attempting to reproduce the situated practices of remittance clinics, and the business and state project failures that come about given their medical "excess"—their immeasurable and irreproducible effects that sustain their very existence.

4.1 Introduction

During my first days of fieldwork in Los Angeles I receive a phone call from a woman I had met the year before at the 2010 World Medical Tourism & Global Healthcare Congress, a networking trade fair with world representation designed for healthcare, government, insurance, marketing, and other agencies interested in establishing and promoting transnational healthcare provision. She is the dentist that had come with the Salvadoran delegation—a small group organized and sponsored by state institutions that emerged at the beginning of the new millennium to promote international trade and investment in the wake of neoliberal policies and reorganization in the region.[1] She had come along with a medical doctor, and a PROESA government representative to "look for patients." The convention was the last event in a whirlwind trip full of meetings with organizations that offer direct services to Salvadoran migrants, such as hometown associations, social service agencies, and ethnic food stores. The dentist belongs to a small cohort of professionals who had received technical advice and funding to modernize her services and facilities to attract "medical tourists" coming to El Salvador. At the convention, she stood behind the table displaying multiple pamphlets in English promoting services in ophthalmology, orthopedics, plastic surgery, and dentistry along with tourist destinations of beautiful sunsets and beaches in the country. During the afternoon I spent at their table, the doc-

1. These institutions were the Agency for Investment Promotion (PROESA) created in 2000, and the Agency for Export Promotion (EXPORTA) created in 2004, which were fused into one agency in 2011; and the Ministry of Tourism created in 2009. USAID's Export Promotion Program (2003-2009) had partially funded participation of Salvadoran business and government organizations in this trade fair in prior years.

tor offered his business card and elevator-pitch on stem cell lung regeneration treatment at his private clinic to anyone that approached him, while the PROESA representative kept tying his shoelaces in boredom, and the dentist kept asking where were the patients.

She is calling almost a year after the convention to know if I have concluded my study and have "some numbers" to share. I explain that my research will not produce "numbers." Still, she insists, she wants to know how I can be of help in understanding where and how Salvadorans travel home in search of healthcare. I am supposed to be calling her for information about Salvadorans traveling home to receive health services, but here she is calling me! It turns out, I would later find out, that the main organization that had emerged to create the infrastructure to support health tourism has folded, and she has been left with a state-of-the-art clinic but with few high-paying patients. In 2005, a USAID-sponsored study reported that medical doctors surveyed received 20 percent of their total income from patients visiting from abroad (USAID 2005), and subsequently a chamber of commerce designed to administer the sale of health services in El Salvador to Salvadorans abroad was established. But by 2011 the association had disappeared. She wonders, where are the patients, and how come they are not coming as the trade institutions and investment experts promised. She sounds frustrated and concerned, while at the same time hopeful that I may help her find these yet-to-materialize patients.

I never find the kinds of patients ready to pay for high-end services in the air-conditioned pristine clinics in the capital either, but clinics and hospitals leftover from the health tourism project of USAID and the Salvadoran government are not hard to locate in my first days of fieldwork. Later, I meet Salvadorans traveling to receive health services in El Salvador in entirely different medical spaces. In improvised medical rooms far away from the state-of-the-art clinics in the capital, I encounter doctors who talk about their work primarily in terms of its rural condition and their role as "town doctors" without mentioning medical travel, tourism, or migration, although they diagnose, treat, and send medicines to Salvadorans coming or calling from abroad. I learn about medical phone consultations as a side note when one doctor pauses, looks at me, looks at his papers on his desk as if unsure about what he is going to say, and quietly tells

me that here something unusual happens, they receive calls from their patients' relatives who live in the US. He proceeds to relate the surprise he felt the first time he was asked to treat someone over the phone, perhaps wanting to stress his reluctance in diagnosing patients that are not physically present or to stress Salvadoran migrants are coming to him, not the other way around. As I meet more and more doctors like him, I learn that their connection to Salvadoran migrants is not limited to the phone calls, nor is it entirely unintentionally and marginally connected to migrant medical networks.

These rural clinics that are now answering the phone calls of Salvadorans that live and work in Los Angeles, New York, Washington DC, or Virginia did not exist when some of those that now call left the country more than thirty years ago. These clinics have emerged as a result of the remittances migrants send to their relatives, the needs and demands of separated families, and the local health needs of rural folks that increasingly turn to private medicine for different reasons. As doctors diagnose and treat more and more patients presenting a variety of health problems, they form informal and formal networks of referrals that feed into newly constructed nearby small hospitals, as well as large and high-end hospitals in San Miguel, the largest city in the eastern part of the country where remittances are highest. The entire landscape of private medicine in El Salvador has changed as a result of remittances and the networks they instantiate. Small-town hospitals now dot the maps of high-remittance receiving areas, and large hospitals and medical service buildings dominate the skyline of San Miguel, a city previously important only for its agriculture and chemical industry. These medical rural clinics far away from the state-of-the-art clinics in the capital, and the technical training and funding given by institutions promoting trade and development, turn out to be enmeshed in the circuits of transnational medicine in ways that do not always feed patients into clinics like those of the dentist.

These rural clinics are nevertheless integrated into transnational flows of capital, circulating dollars from often under-the-table labor arrangements outside El Salvador to large private hospitals with ties to global capital either in the form of purchases (equipment, pharmaceuticals, scientific knowledge), or in the form of loans. Furthermore, these rural

clinics are also part of transnational circulation of patients that seems to only be growing worldwide—Salvadoran migrants join the lines of culturally-alienated or priced-out patients in the US healthcare system seeking cheaper and better access elsewhere. However, they are not the kinds of patients that make medical travel arrangements through international brokers, who choose destinations based on advertised measured outcomes without knowing, or knowing someone that knows the doctors that will treat them. Salvadoran migrants and their families in rural areas, in contrast, circulate through intimate medical networks. The medical practices particular to the rural clinics Salvadoran migrants call and visit, produce and are produced through family-making networks, and as such respond to more than clinical standards seeking to cut costs, increase efficiency, or measure outcomes. Medical practices and services are crucial in the complex process of making families across political borders, long periods of separation, insecure remittances, and uncertain futures in El Salvador. The rural clinic instantiated to engage distant relatives which in turn engender treatment practices that exceed biomedical standards and materialize remittances into care, is what I have been calling remittance clinics. This chapter explores first, the medical travel narratives and incipient medical tourism projects in El Salvador that render Salvadoran migrants and their families "missing" as they circulate through rural affective networks, and second, the difficulty in reproducing those networks and their medical practices as sites through which patients and remittances are expected to be captured and be made economically productive.

I argue that while sustained by remittances and enmeshed in migrant medical networks, remittance clinics enable medical practices that are difficult to reproduce outside the conditions of possibility that marks their emergence. Even small private projects that have tried to enroll Salvadorans abroad into urban medical networks have not been able to quite "capture" those traveling bodies or remittances attached to remittance clinics. The medical travel conjured in remittance clinics seems to occur peripherally to the standardized and formalized medical practices required by medical tourism as it seeks seamless movement across different political, legal, and medical regimes. The chapter first explores the context in which the circulation of Salvadoran migrants from cities in

the US to rural clinics in El Salvador becomes a kind of "margin-to-margin" flow, by drawing a picture of remittance clinics within the narrative of medical travel as a development project. Next, the chapter looks at two medical tourism projects that failed to get off the ground or sustain themselves economically—the case of pre-paid medical services sold by various companies, and the case of state administered healthcare sold to migrants in the US. I suggest that the inability to "capture" patients and remittances into medical networks outside the medico-family spaces of remittance clinics is due to the ways that doctors and patients emerge through the network of family relations and specific medical practices of remittance clinics. Furthermore, the medical excess of non-standard medical practices—the work *sueros* or hospital admissions do to bring relatives into relation—impede easy replication of the remittance clinic in networks that require care to be measurable and standard.

4.2 Medical Tourism and Remittances

Some of the recent studies on medical travel have focused on the medical assemblages created by traveling insurance-poor patients in the North in search of low-cost health services in the South (Sobo 2009; Whittaker 2010; Wilson 2011). The promise of medical travel, at least as seen by the proponents of global medical markets, rests on the possibilities global rearrangements of technology offer to mobile patients worldwide. Today, patients can plan trips via medical travel companies to go to India for cutting-edge treatments in "'super-specialty' marble and glass corporate hospitals" (Solomon 2011, 106), or go to El Salvador in search of stem cell lung regeneration treatments held in "boutique" hospitals equipped with the latest medical tools and instruments. So-called developing countries are no longer only sending patients to the Mayo Clinic for life-saving procedures they do not have, but rather offer what the West cannot offer—high-quality affordable biomedical care. In this figuring, North to South travel enacts the promise of development of the South, opposing a colonial imaginary that mapped "peripheries" as dependent sites unable to produce services typically requiring highly developed infrastructure and knowledge, and "metropolises" as sites rich in access to technologically advanced healthcare. Political and

economic geographies of medical innovation and availability are remapped by the dynamics of the failures of healthcare in the developed world and the possibilities of technology in the South. Harris Solomon (2011) during his fieldwork in Indian corporate hospitals treating traveling patients finds that, "Some Indian doctors engage medical tourism as a form of postcolonial critique, and contend that its popularity marks a repair to the imbalance of medical modernity, whereby the hubris of the West has left its citizens sick and stranded, only to be rescued by India's technological ascent" (106). High-tech medical services in the South seem to promise not only a rebalancing of access to healthcare, but also a repair to the excesses of the hubris of modernity and capitalism—the exclusions, abandonments, and disposals in the North.

In El Salvador medical travel, or more specifically medical tourism as it has been embraced by trade and investments experts, has been advanced as an economic solution to a struggling economy and as a way to make remittances "productive." By the start of the new millennium, economic reports on the slowing economy of El Salvador had repeated countless times the negative effects large flows of remittances were having on the poorly-diversified and small economy of the country (e.g. Cáceres and Saca 2006; IMF 2005; González Orellana 2008). These reports argued that as family remittances increase consumer spending, they drive up imports, and raise prices and wages for non-traded goods, which in turn reduce the competitiveness of exports already suffering from lower returns in a climate of remittance-induced currency devaluation. One of the most-agreed upon solutions that has ended in the mouth of any government administrator that has anything to do with migration and remittances, is to shift family remittances away from consumption and into savings and investment projects (e.g. MREE 2009, 31). But because this shift is very difficult, if not impossible as González Orellana (2008) suggests, social and economic development strategies proposed by institutions like USAID, and the Ministries of Economics and Foreign Affairs, have continued to focus on strengthening and diversifying trade and stimulating the use of remittances on "human capital"—a proven positive use of remittances. Health tourism designed for Salvadorans abroad captures this combined purpose, it introduces high-skilled service as a promising nontraditional

export, and health to be purchased by Salvadoran migrants and their families as a positive investment in "human capital."

By categorizing health services paid with incomes earned outside the country as "exports," the USAID Export Promotion Program made health tourism a priority, closely fostering the creation of an export chamber of medical services that promised to launch the industry into stardom. Although its commissioned market research on "export of health services" (USAID 2005) did not mention Salvadorans abroad as the main object of study, it is clear they were in mind when instead of "medical tourists" the research report used "patients residing abroad who visit El Salvador" (9). The study reported that more than 88 percent of "patients residing abroad" had come primarily to "visit relatives," making evident the patients in question were Salvadorans (16). The export chamber explicitly chose Salvadorans abroad to be its main target market, when it organized in early 2008 the "1st Health Fair for Salvadorans Living Abroad," an open fair selling health services directly to Salvadorans in Los Angeles. But in these initiatives "Salvadorans abroad" remained a category interchangeable with "medical tourists"—what made them a target was not their family-mediated engagements with medicine, but the fact that their incomes were earned outside El Salvador. Importantly, the study reported it found a market already in place, active and vibrant with hundreds of patients coming to specialty clinics in San Salvador and many more to clinics in San Miguel. The chamber was meant to replicate in newly created locations what was already happening in the clinics treating Salvadorans visiting family. The irony was not missed by the critics of the state administration in place at the time, "development" was coming on the backs of Salvadorans that had left the country in the first place.

Supported and promoted by the Ministry of Foreign Affairs and Ministry of Tourism, and with financial and technical support by USAID, medical tourism emerges in El Salvador as a development alternative that not only promises economic growth and job creation, but also the opportunity for health to Salvadorans living in the US. Language and *calidez* (warmth) often figure as key advantages highlighted by physicians and administrators promoting its expansion (i.e. *El Diario de Hoy*, April 26, 2005). In this

developmentalist narrative, medical travel promises the proliferation of medicine through affordability, but also a unique sense of "home" and belonging for those living in an anti-migrant environment in the US. The expansion of modernity on which medical travel relies does not simply indicate the emergence of new protagonists of development. El Salvador re-figures as the site of *calidez* in the context of multiple expulsions of medical markets.

But the change in configuration of origins and destinations in the flows of patients and medical therapies, knowledge, and technology cannot be said to simply reproduce or reverse extractivist or dependency patterns from South to North. Medical tourism complicates center-production and periphery-consumption sites and paths, however it does so without undoing the logic of development that underpins medical differentiation according to relationships of labor, technology, and territory. Medical tourism as proposed by corporations and governments interested in expanding medicine as a revenue-producing industry builds upon the economic tradition of outsourcing that depends on comparative conditions and possibilities between markets on a global scale. The supposed comparative advantage and promise of development promoted by medical tourism ignores the complexities of biomedical expansions and the excesses produced at each site. To view medical tourism as a repair to the excesses in the North would be to ignore the effects of limiting the possibilities of life and health to only those that can move and pay. Medical tourism depends on macro-economic theories of global markets and domestic growth, which position the movement of people and capital in terms of legal, tax, administrative, and labor advantages that many times increase disparities of health rather than reduce them (Roberts and Scheper-Hughes 2011; Solomon 2011; Whittaker 2010; Wilson 2011).

Medical tourism presents a global picture of medical availability and access that ironically relies on differentiated medical populations on global and local scales, while purporting that access becomes more democratic (see critique of 'democratizing' narrative Wilson 2011). Not only does it take advantage of territorial possibilities historically produced through geopolitical power differentials, but also of populations produced by exclusions and exclusivity. For instance, Latin American elites travel to some of the most prestigious

clinics around the world, while poor patients that have been quite literally kicked out of medical markets in the North must now travel to the South in their last hopes of finding affordable life-saving care. Not only elites travel to wealthier nations to seek medical services, "[s]ome medical migrants are so-called 'illegals', undocumented people traveling without tourist visas, including a good many Mexican and Central Americans who avoid crossing via official customs kiosks and who enter the US surreptitiously in search, not of employment, but of American health care at public hospitals, clinics and emergency rooms" (Roberts and Scheper-Hughes 2011, 3). Similarly, uninsured poor patients in the US are not the only ones traveling to developing countries. Many wealthy patients around the developed world travel in search of experimental and expensive therapies yet to be approved by legal and governing bodies in their own countries (Song 2010; Bharadwaj 2008). A doctor in El Salvador for instance, situates the success of his business precisely on the fact that his non-FDA-approved stem cell lung regeneration therapy taps into a patient niche able and willing to pay high prices for something unavailable at home. These different forms of patient flows draw attention to the heterogeneity of populations in movement that articulate the exclusions and exclusivities proper of market logics and biopolitical national projects working on a global scale. Not all flows oppose or affirm well-worn paths of expansion of modernity—medical mobility many times does not obey movements guided by local/global, center/periphery, North/South geopolitical economic assemblages (on kidney transplants in India see Cohen 2011). Salvadoran migrants and their families that call and visit rural clinics in El Salvador form part of this broad picture of exclusions happening on global and local scales, but move peripherally to the organized response to build medical infrastructures to take economic advantage of those flows.

The clinics where I meet Salvadorans living and working in the US and their families could hardly make it into one of the health tourism brochures created by any of the institutions promoting trade and investment. Although clean and organized with great effort, these clinics are often permanent operations in seemingly improvised setups—the sun filtering through broken shingles, the outhouses, the water stored in oil barrels, the IV bags hanging from nails on walls are a constant reminders of their precariousness

(Figure 4.1). With minimum technology—sometimes just a stethoscope, otoscope and ophthalmoscope—doctors say they have learned to diagnose a wide variety of health problems that elsewhere require sophisticated machines and materials, like appendicitis and polycystic endometriosis. Far away from hotels and resorts, spas and malls, airports and highways, these clinics are at the center of families separated and united by migration. They operate through financial and communication networks engendered by more than thirty years of constant migration. Salvadorans living in the US enter these clinics through the mobile phones of their relatives, through their remittances, and through the door when they can cross national borders easily. Doctors send medicine with relatives, friends, and courier services, and receive money through informal and formal remittance channels, talking all along with the string of people that make possible these medical encounters. And although these patients may end up in specialty clinics in San Miguel or San Salvador, they seem to be the wrong kind of patients in clinic setups outside the channels of referrals mediated by intimately known doctors, relatives, and friends.

Figure 4.1. Façade of private clinic in small town announcing hours and services.

When patients need more specialized care, doctors send them to specific doctors with

whom they already have a relationship. Doctor Cardona for instance, refers his patients to a handful of specialty medicine doctors he personally knows, located in the same hospital where he rents space to work on the weekends. He sends patients to specialists he knows well all the way to San Miguel, rather than asking them to find a specialist in much closer towns. He does not make a referral to see a cardiologist, he makes a referral to see doctor-so-and-so. Doctor Escalante, who works in a slightly bigger town, tells me that patients self-diagnose often and many times go directly to the specialists crowding the streets of nearby cities. They go to specialists recommended within an intimate network of relations mediated through remittances and obligations.

I hesitantly call these circulations from "margin-to-margin" to highlight the kinds of geopolitical and economic exclusions that mark their emergence, but I do so hesitantly because they are not unimportant, peripheral, or disposable. Neither are they marginal in the sense of being deterritorialized or decentralized processes—they go through central bookkeeping systems such as banks and remittance service agencies. The kind of medical services that these circulations make possible, reflect the desires and conditions of the relationships that made them possible in the first place. These relations articulate medicine not through national development ethos, or outsourcing economic strategies, or foreign investment imperatives, but through family relations, and the affects and effects of obligations contained in remittances. Sarah Horton (2013) has talked about the inequalities advanced by remittances, as they create a form of privatization that exacerbates the already unequal access to care in migrant villages. Ironically, these clinics that seem to work through intimate and affective networks of personal relationships, also reflect the move toward making the individual subject responsible for its own health, reserving health for only those that can pay. There is a vibrant, dynamic, and complex transnational medical market in El Salvador, but not one of the kind envisioned and expected by those institutions funding the modernization of clinics to welcome medical tourists. Salvadoran migrants, put simply, are not tourists, and as such seem invisible to the doctors looking for medical tourists to fill their appointment books.

Anthropologists Elizabeth Roberts and Nancy Scheper-Hughes propose a critical shift

in the framework of analysis of travel in the pursuit of biomedical treatment, bodily alteration, or biological logics noted by the use of the term "medical migrations" instead of "medical tourism" (Roberts and Scheper-Hughes 2011). They argue "medical tourism" describes social and medical reality actively promoted by governments and by private companies in parts of the so-called developing world, while "medical migrations emphasize their production within particular political-economic configurations of globalized bio-medicine, which involve disparate and unequal distribution of health sickness, health care, and the maintenance of borders between bodies, social collectivities (classes, castes, races), polities and nation-states" (4–5). In this sense, I analyze the medical migrations of Salvadorans, which include the medical doings of their relatives and the projects they motivate. My framework of analysis through remittance clinics includes not only what is produced by travel in the pursuit of biomedical treatment, but also what is produced by remittances, remotely diagnosed bodies, medical needs of relatives—in other words, what is produced by the processes of becoming relatives and the material practices produced by migration, and by the many ways families are with one another.

4.3 Failure 1: Pre-Paid Health Plans

During fieldwork in Los Angeles, I volunteer at the Salvadoran Consulate the days it offers health information, advice, and screenings. Some mornings at the end of 2011, the Consulate can look like a small street market in El Salvador: women with baskets filled with Salvadoran sweet bread, others with *tamales*, and a man in a wheelchair with candy, pens, and calling cards, compete to sell their goods among an impatient crowd awaiting for documents. A woman among the sellers tries to grab the attention of a middle-age man offering him an unusual product, the *Plan de Salud Familiar*, a pre-paid health plan to cover his family's medical services in El Salvador. The *Plan* has a curious arrangement—a Salvadoran non-profit with a focus on family planning provides the medical services, a hometown association in Los Angeles with humanitarian and development projects in rural El Salvador sells the plan at venues frequented by Salvadorans, such as the Consulate, ethnic food stores, and courier services. The *Plan* comes on the heels of a dozen other

failed projects I started following in pre-dissertation fieldwork—they all target Salvadorans living and working in the US to purchase health services in El Salvador for their families or for themselves.

When I arrive in San Salvador a few months later, I find many other similar business projects. Curiously, they disappear as soon as they emerge, just as the projects that inspired the research for this dissertation. Traveling on a main highway exiting the city toward the ocean, I see a blue billboard advertising a different plan, the *Plan Salud ES*; we're traveling too fast for a picture, but I manage to see the familiar logos of a local fast food and pharmacy chain. I ask the driver to return, but the next turnabout is difficult and far away. By the time I return to the highway, about a month later, the billboard is gone. I learn that a corporation specializing in financial transaction services sells the plan; a local pharmacy chain and the healthcare network of an insurance multinational provide medical services. The plan can be purchased at more than 300 stores that use the services of the financial transactions company, which enables customers to pay bills, purchase mobile refills, receive government gas subsidies, and, importantly for this discussion, receive remittances.

These plans, and the many others that sell similar products, are assemblages of a multitude of institutions and interests that come together on the link between remittances and health. I wonder why that nexus seems unable to be sustained by so many medical business projects given the powerful institutions that support them, from multinational insurance companies and financial organizations, to government agencies. What breaks down in attempting to link remittances to health through the sale of pre-paid health plans to remittance-senders and their families? What do health and remittances have to do to sustain each other in a relation in El Salvador? Health is something particularly sought in remittance economies like those I observed in rural areas, not only because remittances allow access to private care in the face of sickness, but also because of the capacity the medical space has to bring doctors, patients, and relatives into relation—to make each other act and become doctors or relatives in the process. Remittances materialize a response to relatives, a re-action to their needs. They materialize the ability of relatives

to be affected when their relatives are sick, bringing into being kin attachments and obligations.

Doctor Benítez, the doctor who came with the Salvadoran delegation to the 2010 World Medical Tourism & Global Healthcare Congress, now knows this all too well. But the lessons about what the medical space does in migrant family networks perhaps came with insurmountable demands—he has abandoned a series of projects designed to sell health services to Salvadoran migrants and their families like many other medical enterprises have done in the past decade. He has now turned to building a cutting-edge stem cell lung regeneration clinic in a prestigious hospital in the capital for medical tourists seeking experimental treatment not approved by the FDA. Doctor Benítez' business inventions offer an exquisite site to analyze the translations into care that remittances are not able to do when they are extricated from their attachments. His daring business ventures reveal the power remittances have to invent sophisticated setups to transfer them, but also demonstrate the situated practices of remittances that resist their endless movement.

Doctor Benítez's first project was a health advice call center staffed by medical doctors. In early 2000s an international bank enrolled more than half a million of its credit card holders in Guatemala, El Salvador, and Honduras in car insurance and roadside assistance service that cost $1 per month. The opt-out-only[2] services were offered by a well-known insurance multinational, which approached Doctor Benítez to add health advice over the phone and ambulance service to the package. The initial idea to offer badly-needed roadside emergency assistance in the region[3] had quickly given way to adding a health advice line that could recommend therapies, arrange medical consultations, or send ambulances.[4] The doctors and pharmacies recommended by the advice service had contracts with Doctor Benítez to offer small discounts in exchange for referrals arranged through the call

2. Credit card holders were automatically enrolled and had to opt out by calling the credit card company if they did not want the service.

3. The business was meant to fill a gap in roadside emergency response in the region. In El Salvador state funded emergency response has slowly improved over the years, finally adding an emergency number in 2012.

4. The medical doctors would not try to diagnose, but instead recommend the best course of action to take to address the health problem. But their recommendations included home remedies, OTC drugs, or pharmaceuticals, all of which could be bought at discount prices at the recommended pharmacies.

center. Business was booming. Doctor Benítez got paid for each credit card holder automatically enrolled in roadside/health emergency service, not for each call answered. He soon thought the call center could answer more calls and convinced a Salvadoran bank to use the service. This bank decided to offer roadside/health assistance as a promotion to incentivize remittance transactions. The remittance sender in the US would get a variety of promotional gifts, one of which was a roadside/health assistance card their relatives would receive at the time of remittance pickup in El Salvador.

Here is the first link to remittances. The business of transnational money transfers is a high-margin business, resting on fees of up to 20 percent of the principal sent in some circumstances (Fajnzylber and López 2011, 14).[5] In 2004, when Doctor Benítez approached the bank, El Salvador received 2.54 billion in remittances, which represented a 21% increase with respect to 2003, and fees averaged 5.75% for each $200 sent, making the business of remittance transfers one of the fastest growing and most lucrative (Hurtado and Palacios 2006, 4–5). Furthermore, the Salvadoran government was making efforts to formalize remittance transfers to improve data collection, increase transparency, lower transfer costs, and arguably, indirectly collect taxes.[6] Although the bank had great economic incentive and political pressure to increase the number of remittance transfers, it saw the promotional gift as a one-time expenditure to add new customers and was, thus, unwilling to renew it. Doctor Benítez laments that the bank was also not interested in allowing remittance senders or receivers to individually purchase the health advice service. Presumably, the bank could not envision an increased number of customers as a result of offering the sale of a health good. In other words, it did not see health as a strong enough attractor to remittances. Here is the first fracture in Doctor Benítez's attempt to link remittances to health. But Doctor Benítez was at the time convinced that if remittance senders were offered the opportunity to buy health advice over the phone, they would.

5. The World Bank has argued that exorbitant fees are bad for development—lower costs promise to stop the drain on resources of poor migrants and their families, increase flows through formal channels, and improve financial access for the poor in developing countries (World-Bank 2006, 135). The objective to reduce global average total costs to 5% was adopted by the G8 meeting in 2009, and again by the G20 meeting in 2014 (World-Bank 2015, 8).

6. El Salvador does not collect taxes on remittance transactions, but it does collect taxes on the revenues these transactions produce.

The first test to his conviction came soon. When compulsory enrollment of additional paid services in credit card bills was outlawed in Central America, Doctor Benítez had to convince credit card holders to willingly purchase health/road emergency service. But sales never picked up, almost no one was buying the service. Undeterred, he formed another company and set out to sell the health advice services directly to individuals, this time to those he thought had the least access to health and would be most willing to pay for health advice over the phone: Salvadoran migrants in Virginia. He approached a local supermarket popular with Salvadorans to sell a health calling card for $10. Callers would dial a toll-free number in the US to receive health advice from a doctor answering the call in El Salvador. But the network Doctor Benítez had built in El Salvador with pharmacies and doctors was missing, and advice doctors could not even guide callers to the isles of OTC remedies in US drugstores. Here is the second fracture in attempting to link migrant-dollars to health. The network could not be replicated. The enrollment of pharmacies and doctors in an arrangement of discounts in exchange for patients was not only not transferable, but was also dependent on Doctor Benítez's professional connections and persuasion skills only extant in a small country where everyone in the health industry knows him. But more importantly, the break may have had to do with something Doctor Benítez did not consider at this time—perhaps migrants were uninterested in filling their lack of access to health with advice from an unknown doctor, directing them to strange isles of medicaments. Could it be that these migrants were already calling doctors in their hometowns vouched for by their mothers and sisters, and made possible by their remittances? Soon Doctor Benítez would realize that neither health, nor its business networks, is as ubiquitous as he once thought—the doctor that answers the phone and the remedies that are suggested matter, they cannot be easily exchanged for general versions of themselves.

Helped by the momentum that trade and investment institutions had built to create a medical tourism industry in the country by 2006, Doctor Benítez transformed the health advice line into more complete health services for Salvadorans traveling to El Salvador and their families residing there. He started by offering medical checkups to visiting

Salvadorans and access to the medical advice line to their families. Salvadorans visiting their relatives could purchase "MediCheck Platinum" for $483, and have a doctor come to their home to draw blood, measure their blood pressure and weight, collect urine and stool samples, and take an electrocardiogram with a portable device that would send the signal to their online platform (Table 4.1). Patients would receive a medical evaluation of their lab results online, be able to interact with a medical doctor in real time, and receive referrals to local doctors and hospitals that would, like before, offer discounts. For the families residing in El Salvador, Doctor Benítez offered "MediNet Familiar" for $96, which consisted of 24-7 access to the health advice line, two medical home visits, six clinical consultations with specialists, two ambulance transfers, and unlimited discounts. Although he marketed the products heavily to Salvadorans in Los Angeles, Washington DC, and Virginia, there were not enough sales to keep the business open. Here is the third and final fracture in attempting to link migrant-dollars to health. Migrants and their families could not be convinced to enroll in online and telephone health diagnostics with referrals to unknown hospitals, doctors, and pharmacies.

Doctor Benítez acknowledges that Salvadorans were not coming to visit just any doctor, they're coming to visit a doctor they trusted. He says,

> Eso [turismo médico para los salvadoreños en USA] no nos iba a ayudar en nada por diferentes razones, y una de ella es de que, eh, el servicio que se vende es un intangible, o sea usted no lo puede probar, no tiene ninguna referencia del asunto, y la única forma de que usted tiene es la confianza que le pueda generar la persona que le está ofreciendo el servicio. Entonces una agencia de viajes a la que usted llegue y diga "Mire fíjese de que yo quiero, eh, que yo tengo piedras en la vesícula y quiero que me operen," ¿Qué le van a hacer?" ¿Qué le va a contestar el de la agencia de viajes?
>
> [That [medical tourism for Salvadorans abroad] was not going to help us in anything for different reasons, one of those reasons was that the service that is sold is an intangible, meaning you cannot try it out, you do not have any reference, and the only thing you have is the trust that the person offering the service can generate. You can go to a travel agency and say "Look, I want, eh, I have stones gallstones and want to have an operation." What are they going to do? What is the travel agent going to answer?]

His rhetorical question suggests that the travel agent cannot generate trust for health

Table 4.1. Pre-paid health package sold by private health clinic.

MediCheck Platinum	$483.00
Description	Medical checkup for persons between 35 and 50 years old. MediCheck Platinum is a complete interactive medical checkup online, which offers a broad perspective of your health status, without making you move away from your house or office and without administrative red-tape.
Lab exams	Glucose, LDL & HDL cholesterol, triglycerides, uric acid, transaminase GP & GO bilirubin, total proteins (albumins, globulins), calcium, potassium, VDRL, HIV, hemogram, general urine exam, general stool exam, gamma GT, creatinine, blood urea nitrogen, alkaline phosphatase.
Extra	Electrocardiogram of 12 derivations online, arterial pressure, weight.
Advantages	Health profile online: the user will receive a complete individual written report including specific recommendations and results of exams; the health profile accompanies an interpretive analysis of the results done by our doctors; referrals to our network of specialists with discounts, in case needed; discounts on additional exams like x-rays; all services are at home; contacts and results online: internet, fax and phone; same-day results.

Source: http://medicinayturismo.com accessed 2009, corroborated in interview with Doctor Benítez in 2012.

service to an unrelated person—the agent is not a mother or an aunt, an intimate relation through which some Salvadorans enter private health service networks. Health, Doctor Benítez says, is an intangible you cannot try out before purchasing, and thus you must rely on the experience of others. But for the patients in the remittance clinics I visit, experiences are only transferable between trusted relations—not anyone's positive experience can be trusted. This is quite different from the kind of trust that online video testimonies, or comments coming from anonymous or unknown users can generate for other publics. But I speculate that Doctor Benítez's failure in successfully linking remittances to health has more to do with the work that medicine is expected to do for migrants and their families, than with the inability to garner trust from an unrelated person. The medicine offered in remittance clinics works to bring people into specific relations, especially separated relatives. Relatives come into being through medical practices that make the bodies of distant relatives present through, for instance, the mobile phones of mothers and sisters. The telecommunication established by a mother accessing the health advice

line does not bring families together in the way the telecommunication established by a son ringing the mobile of the mother to get advice from the mother's doctor does. In the latter, the mobile phone ceases to be a telecommunication or medical device, it becomes a relative. This is the capacity I speculate "MediNet Familiar" does not have. To sell medical services to Salvadorans abroad, Doctor Benítez would not only need to enroll their relatives in El Salvador in the use of his medical network, but also the service would have to bring relatives into being.

There is another way in which Doctor Benítez's business venture was not able to link remittances to health. "MediCheck Platinum" and "MediNet Familiar" emerged out of the momentum of health tourism initiatives inspired by the USAID-sponsored study, which conceived of patients coming to seek health services in El Salvador as tourists for whom, presumably, medical service quality can be guaranteed through institutions and legal frameworks. But, as said earlier, Salvadoran migrants are not tourists. Medical practices of the pre-paid health plans do not seem able to translate migrants into tourists, nor remittance clinics into "MediNet Familiar." What I mean by translation here, is a transformation into something that could preserve the same function. Migrants cannot do the work of tourists, the latter are not expected to have attachments to their physicians, trust them only if trusted by their relatives, respond to the needs of their kin through medical relationships. Remittance clinics cannot do the work of "MediNet Familiar" either, the latter does not work to bring relatives together as explained above.

The link between health and remittances enrolls many interests on different scales, such as multinational financial, insurance, and telecommunication companies; local banks, pharmacies, and fast-food chains; government and consular networks; and non-government organizations and hometown associations. But all the power that these companies are able to draw is not enough to guarantee the attachment of remittances to health. What attaches remittances to remittance clinics—the medical practices that can materialize affects, make relatives respond to their kin—is simultaneously what reproduces remittance clinics and what makes remittance clinics unable to be transformed and replicated into something like "MediNet Familiar." Affect is a "cutter" as well as an "extensor" of net-

works. Those medical spaces that are able to reproduce the complex affective networks of separated families seem to reproduce themselves, those that do not, die off.

Many of the subsequent pre-paid plans that have emerged since the failures of Doctor Benítez's business ventures seem to recognize this problem and now deliberately market to the family-making process proper of remittance clinics. These new ventures recognize the affective space that health services are asked to perform, and thus, do not try to sell medical services empty of its relations. Rather, they advertise health products by foregrounding the action of buying health as a form of engagement with their kin. For example, the *Plan de Salud Familiar* sold at the Consulate and other venues where Salvadoran migrants congregate in Los Angeles, engages the buyer with a statement that puts them already in response to their kin, "Y ahora que tú puedes ayudarlos, protege a tu familia con el Plan de Salud Familiar" [And now that you can help them, protect your family with the Family Health Plan]. The sentence elicits the obligation that engages relatives, and makes evident that what is sold is also the manifestation of the obligation. Interestingly, the woman going from chair to chair at the Consulate selling this plan elicits another kind of affective response that makes the doctor come into being, not as manifestation of care, but as manifestation of protection against being defrauded by relatives. The plan is also sold as a guarantee to fulfill the sender's intended use of remittances. This plan's services in El Salvador, however, resemble more an anonymous medical network setup in which doctors are interchangeable and not chosen, than the individual private clinics in which treatment practices can be negotiated, and, thus, may not be able to do everything that migrants ask remittances and health to do. Three months after this plan was launched, the only plan sold had been the one I bought! This plan, just as the others that have failed before it, has its days numbered if its medical practices are not able to treat the medical body with all its relations.

4.4 Failure 2: Social Security Insurance

The Instituto Salvadoreño del Seguro Social (ISSS), the national social insurance system traditionally financed through compulsory contributions of employers and employees in

the formal economy, first noted its interest to allow voluntary enrollment of "Salvadorans abroad"[7] in 2006 (ISSS 2006, 27). More than a decade later the system remains closed to them. Who participates in the system has been a contentious political matter since the inception of the institution, and although today changes to the categories of eligible workers only require institutional approval sanctioned by the President, until recently the debate on eligibility and obligation got tangled in the often impossible approval process of Congress. The ISSS, like other social security systems in the region, is a social insurance program that covers contingencies such as old age, disability, sickness, maternity, and death of contributing members only.[8] Beneficiaries of contributing members—spouses and children under 12—are entitled to health services and funerary cash aid. Its sustainability depends on the right balance of risks of contributors and beneficiaries, and on the salaries of contributors that determine the amount remitted into the system. Too many low-wage, high-risk workers would bankrupt the system just as much as too many old, sick retirees. Since its inception, farm and seasonal workers, groups earning the lowest wages in the country, have been denied access, while salaried workers and their employers in the formal economy, groups with higher than average wages, are obligated to pay into the system. In 2010, domestic workers marked a dramatic shift in the gatekeeping mechanism of the system, they were the first group that could *voluntarily* become members, albeit with limited benefits.[9] The actuarial analysis of the ISSS calculates "Salvadorans abroad" are an attractive group to extend access to given their comparative higher incomes with respect to national averages. Although great forces at the national and international levels have gathered to promote the entry of "Salvadorans abroad" into the system, either advocating the right for protection of all workers, or the need to expand the high-salary contributor base, "Salvadorans abroad" have yet to be allowed enrollment.

The problem of giving "Salvadorans abroad" access is not only a debate about their

7. I keep "Salvadorans abroad" in quotes when it refers to a category of worker defined by the ISSS.

8. Although the Social Security Law establishes an obligation for unemployment insurance, the system does not provide any at this moment. During 2009-2010 an emergency regimen offered health benefits for up to six months to contributors who became unemployed (ISSS 2011, 11). The ISSS also administered pensions until 1998, when they were privatized (PNUD 2007, 194).

9. Domestic workers only have access to health and maternity services. Executive Decree no. 74 announced in El Diario Oficial of January 6th, 2010.

legal eligibility determined by actuarial and economic sustainability soundness, or by the political will of government administrators, it is also locked in the perception that remittances can flow endlessly through exchanges of mutual satisfaction of needs and desires. In other words, the failure to open the system may have more to do with the limits of remittance markets and networks, than with political will and long-standing debates about who is an entitled worker. A worthwhile analysis of the problem could focus on the inability to gather enough interest in the project from key institutions and players, including the interest of Salvadorans abroad, or on the logistical and technical challenges to collect payments and guarantee service without crippling overhead. However, here I want to turn my discussion to a more speculative reasoning and sustained analysis on the expectation that remittance markets can be infinitely extended by meeting the health needs of remittance senders and their families, and the economic and political needs of social insurance institutions. Linking remittances to health services is not only a matter of matching preexisting needs or desires. The ISSS project to open voluntary enrollment to "Salvadorans abroad" packages health goods in anonymous medical networks empty of the intimacy that is often sought by migrant families. What is interesting too in this case, is that the flows of remittances are not only determined by the negotiated agreement of powerful economic and political actors, but by the work that remittances themselves are allowed or disallowed to do to bring families into being. The failure to open the system can be said to be the failure of remittances not being able to do what families ask of them. This discussion is decisively speculative because the project hasn't been launched and I do not have any empirical evidence to determine if indeed remittances don't flow into the ISSS. I look at how the project was designed to attract remittances, and speculate on why remittances may be hard to capture if attracted in this way.

Leonel Flores Sosa, a Salvadoran who migrated to the US during the eighties and who returned to be the director of the ISSS during the Mauricio Funes administration (2009-2014), has been perhaps the most visible champion of the project to offer migrants and their families access to the ISSS. His commitment does not only come from his own political conviction to advocate for social protections for migrants. There has been a push

to increase social insurance coverage by institutions such as the Ibero-American Social Security Organization (OISS),[10] and the Inter-American Center for the Study of Social Security (CISS),[11] which promote social security as a biopolitical and development project to improve the economic and social wellbeing of workers through instruments that protect against adverse eventualities. In 2001, the country had the fourth lowest social insurance coverage in the region at 16 percent of the population (Mesa-Lago 2008, 174). By 2006, when the CISS started to directly give technical advice to El Salvador to expand coverage, the ISSS calculated it covered 18 percent of the population (ISSS 2006, 27, 11).[12] The year before, the OISS had gathered enough support to pass an agreement to specifically address the loss of social insurance protections of migrants, which took the form of an agreement of reciprocity in recognition of pension contributions and health benefits among signatory countries.[13] In El Salvador this attention to migrants materialized in a project to open social security enrollment to "Salvadorans abroad" as "an approximation to an Individual Voluntary Insurance" (27). "Salvadorans abroad" were meant to "open the door" to the highly debated access to "independent workers," a category of workers that has yet to be eligible to voluntarily or forcibly participate in the ISSS. Employers with at least one employee are obligated to participate, but self-employed individuals of any kind—professionals, technicians, business owners—are not allowed to pay into the system.

Voluntary enrollment came with a big caveat, it abandoned the social safety net that social security insurance was meant to provide in the first place—cash payments for loss of wages in the case of disability, sickness, or death are explicitly excluded. The first design of the voluntary enrollment of "Salvadorans abroad" project had an interesting look, it resembled one of the health packages that Doctor Benítez tried to sell that same year! In 2006, the ISSS presented its project to the "Presidential Forum with Salvadorans

10. The OISS is an international organization with representation from the International Labor Organization, the Organization of American States and the International Association of Social Security.

11. The CISS is an international organization with origins in the International Labour Organization.

12. My estimates using 2014 revised population figures puts the total population with ISSS coverage at 22.8 percent for 2006, although the PNUD published that only 11.2 percent was covered that year (PNUD 2007, 206).

13. Convenio Multilateral Iberoamericano de Seguridad Social http://www.oiss.org/Que-es,5335.html accessed June 2016.

Abroad II," a large convention organized by the President designed to produce concrete proposals for Salvadorans abroad to invest in the country. The ISSS' project as well as the meetings echoed the tune of other development projects of the time, such as the USAID project to develop health tourism. The ISSS proposed to sell pre-paid health services that included a limited number of medical consultations, pharmaceuticals, and tests per year (Table 4.2), excluded pre-existing conditions and catastrophic health events, and required a yearly single up-front payment. The transformation of social insurance from a social safety net enacted through the obligatory participation of workers and industry into a pre-paid health-only service available for individual out-of-pocket purchase, makes evident a political move to make social security become an individual choice rather than a shared responsibility. According to the ISSS, Salvadorans that evaluated the project in focus groups and through comments collected at the Presidential Forums were not interested in buying such limited services. Presumably, the ISSS was just one more seller of health goods among many others better competitors, like Doctor Benítez who offered at-home top-end services.

But what I want to call attention to is that remittances were not successfully attracted not only because the product may have been considered too limited and undesirable, perhaps even offensive in its evident privatization of care under the cloak of expansion of social security coverage, but also because remittances here enter only in exchange of private property (the health good), empty of their affective capacity to bring relatives into being (see Strathern 1996). My argument is that the purchase of health services for family members is not a ubiquitous transaction that can always and everywhere materialize the obligations that make relatives come into being with one another. For remittances to be able to materialize those obligations, what is exchanged must also work in enabling those relations. In this case, as well as in other cases of pre-paid health plans that cannot be transformed into obligations that engage relatives, remittances stop. This is not to say that remittances are not involved in health markets, clearly they are, as demonstrated by the proliferation of private health clinics in rural areas in high-remittance receiving parts of the country. But remittance networks have specific edges, they stop when relatives

Table 4.2. ISSS Plan to expand coverage April 2007, slide 8.

Benefits	Individual right per pre-paid package to access service centers within the institutional network, defined according to geographic location and level of complexity (community clinics, and medical centers).
Number of consultations	3 consultations per package, not per specialty. Access to general medicine, internal medicine, gynecology, and general surgery.
Number of prescriptions per consultation	3 prescriptions per consultation, from the LOM list.
Number of laboratory exams	One of each type, and one follow up. Types of lab exams include hemogram, general urine exam, general stool exam, blood chemistry (cholesterol, triglycerides, uric acid, clotting time).
Number of specialized exams	2 simple x-rays in a period of one year, 2 electrocardiograms in a period of one year.
Dentist visits	2 consultations for general dentistry per quadrant according to current norm.
Checkup for adult male	2 consultations with an internist, 2 consultations with a nutritionist, 1 consultation with a technician, general checkup exams according to risk that could include all those allowed in the package.
Checkup for adult female	Vaginal cytology, mammography, bone density test.

Source: Presentation slides shared by ISSS administrator interviewed December 2012.

cannot be enacted. In the remittance networks in the rural areas I observe, relatives are not infinitely connected by merely the connection of blood. José, in section 2.3, no longer has contact with the daughter who migrated without his financial help. This daughter, who migrated with the help of her husband, no longer calls or responds to his needs in any way. She is his daughter, but is not a relative, a person that is affected and responds to him. Relatives are not infinitely connected; their networks expand through remittance exchanges that have the capacity to *make* relatives.

The ISSS project has evolved since those first "approximations" to open voluntary enrollment. The 2012 version of the project included full health access with a monthly payment structure similar to the compulsory payments of salaried employees in the country. They would be expected to pay $68.57 a month for health-only services for themselves and their beneficiaries. This figure represents close to the total contribution allowed by

law, which is split between employer and employee, and entitles workers and their beneficiaries to protections of lost wages and complete health services.[14] "Salvadorans abroad" would not be entitled to cash payments for loss of wages in the case of disability, sickness, or death as their counterparts are, and neither could they make use of emergency healthcare in case of accidents, since they are out of the country. The actuarial analysis starts to make sense, "Salvadorans abroad" would be an absent self-employed contributor that would put little strain on the system, while contributing the maximum allowed regardless of what they actually earn. Opening the ISSS to "Salvadorans abroad" in this way, abandons the safety nets meant for the especially vulnerable in favor for voluntary enrollment in health-only services open to those that can afford it. The irony of allowing "Salvadoran abroad" enrollment before the same right is given to independent workers inside the country goes without saying—a self-employed worker has to leave the country in order to have the privilege of purchasing ISSS healthcare with their own money!

The ISSS sees open enrollment for "Salvadorans abroad" primarily as a comparatively affordable health insurance for spouses and children under 12, which may very well be much higher in the private sector. It expects affordability and the need for health insurance of spouses and children to be natural and infinite attractors of remittances. But remittances are not only sent to wives and children, they are sent to parents, siblings, grandparents, godparents, neighbors, and friends. According to the ISSS's own outsourced study, "Salvadorans abroad" would be less willing to buy services if those who they sent remittances could not be listed as their beneficiaries (Hadler and Hinojosa 2012, 3). The recognition of only two kinds of relatives already limits the connections that can bring remittances. But the ISSS clinical space itself also makes difficult for remittances to do what families expect them to do.

The families that I am talking about are the families that receive remittances in the

14. Salaried employees are required to pay 3% and their employer 7.5% of monthly employee income, for a total contribution of 10.5%. In 2012, the salary determining the maximum contribution limit was $685.71, which increased to $1,000 in 2015 (ISSS 2015b, 25). These are higher than average contributions in the region—in 2006, regional averages were of 2% for workers, and 6% for employers (PNUD 2007, 212). In similar systems where self-employed workers are required to enroll, they pay the total contribution percentage. Even in the US the Social Security Tax for self-employed workers amounts to the sum of stipulated contribution for employee and employer.

rural areas and visit remittance clinics. It's possible that these are not the intended families that the ISSS wants to enroll. But in the spirit of speculating why remittances may be hard to enroll in the ISSS, I consider how the clinical space in the ISSS would have a hard time to be converted into a remittance clinic. The hour-long visits to Doctor Cardona to seek advice for land issues, the demand of "medically unneeded" prescriptions and tests by patients, the economy of touch, the affective care practices, the doctor-patient accommodation and adaptation via translations, and the overall negotiation of care and prescription practices that remittance clinics allow, could hardly be imagined in the highly controlled, standardized, and measured practices of the large institutional healthcare system of the ISSS. Like in most health institutions, clinical encounters are timed, and their outcomes measured and evaluated. Prescription practices depend on international protocols observed by the WHO and PAHO. In fact, patients come to private small rural clinics to ask for their *sueros* precisely because they cannot get them at any of the health institutions they can access. Remittance clinics are not prone to travel, to be easily transported and recreated elsewhere just because what they offer is biomedicine, a knowledge system abstracted from bodies thought to be ubiquitous.

In places like El Ocotal where most work remains agricultural, artisanal, and informal, the protections of the ISSS are largely absent. With so few salaried workers in rural areas and the entire eastern region, the ISSS does not offer its own services, instead it reimburses private and public institutions for services rendered to ISSS members. The protection of eventualities of work accidents and old age in these areas comes in the form of family obligations. People here react in horror when I say I do not have children, godchildren, or any dependents. They suggest I find a godchild in this town before I leave. Not having family attachments that can respond, that can act, that can be affected when accidents happen and old age sets in is perhaps one of the most unimaginable circumstances in this area. Social security emerges after WWII in Latin America as an institutional response to eliminate this kind of filial responsibility and make it a shared burden between workers and industry. Making the ISSS a voluntary health-only insurance for children and spouses taps into the creation of intergenerational obligations, while it abandons the protection

of accident and old age of workers. Social security becomes equivalent to a private health insurance provider, and no longer responds to the eventuality of accident, sickness, and death of workers. This is a strange rearrangement. The very institution that comes to shift the burden of responsibility of accident and old age from family relations to worker relations, now tries to sustain itself through the family relations that it tried to cut in the first place. Why would Salvadorans want to enact their filial obligations through an institution that was born out the desire to sever them? Perhaps family obligations are difficult to enact in the medical space of the ISSS not only because the medical encounter is standardized and tightly controlled, but also because its political aim at birth was to eliminate them. In the end, remittances seeking to enact obligations may not want to enter the ISSS even if indeed it offers the most affordable health insurance in the world.

4.5 Conclusion

Although the remittances entering the national economy through rural clinics leave the Salvadoran economy shortly after they entered into it, they stay long enough in the country to pay for labor—a distinction that sets them apart from remittances spent on imported consumer goods, which are said to only "touch down" and leave the country without contributing to its economic growth. As such, medical remittances contain a promise dear to institutions promoting economic growth based on higher salaries for skilled labor. This promise fuels the political and economic support to expand and formalize the phenomenon of the rural clinic to other spaces such as the dentist in the capital. Furthermore, these rural clinics are also part of transnational circulation of patients that seems to only be growing worldwide—as culturally-alienated or priced-out patients from US healthcare increase, healthcare in El Salvador has the promise of growth. This macro-economic and macro-social analysis is the background that motivates the building of a medical travel infrastructure that expects these distinct capital and patient flows to be natural effects of contemporary global markets. But the question that the dentist asks when she calls to ask for my help in finding patients, reveals a wrinkle in the otherwise seemingly perfect economic plan. The patients on which the ISSS, Doctor Benítez, or the dentist

have predicated their growth seem to be missing. But they are hardly missing, they just circulate elsewhere.

Global economic conditions, such as depression of real wages and increased privatization of healthcare, that simultaneously mobilize populations in search of lower-cost medicine, and make certain destinations more affordable, are not the only conditions that encourage Salvadorans to seek health services in El Salvador. Remittances end up being used in health services not only because they offer affordable medical services for the families of migrants in El Salvador. Remittance clinics allow remittances to do what families ask of them, to act out a response and be with one another. In this chapter I have explored the medical travel narratives and incipient projects in El Salvador that render Salvadoran migrants and their families "missing" as they circulate through rural affective networks, and the difficulty in reproducing those networks and their medical practices as sites through which patients and remittances are expected to be captured and be made economically productive.

The "failures" explored in this chapter are not about the impossibility of remittances to engage the economy of affects of migrant families. When I say that the ISSS or the pre-paid plans of Doctor Benítez have a hard time capturing remittances because their services do not allow for the affective demands of migration, I do not mean to suggest that money exchanges of remittances cannot capture those economies well. On the contrary. As evidenced by the proliferation of remittance clinics in the rural areas, remittances have an extraordinary capacity to engage in affective exchanges. In fact, remittances *make* affective exchanges. Affective demands make markets. Bruno Latour and Lépinay (2009), reading Gabriel Tarde, the author of the 1902 *Psychologie Économique,* asserts "passions" make economies:

> It is necessary for there to be trust for the first transaction to come into being; it is necessary to loosen the fixation of *Homo economicus* on the lure of profit because there needs to be also passion and risk taking in order to bring the economy towards new paths through the emergence of small differences. Trust, much like invention, creates new groupings; it folds the economy in a certain way which will then be confirmed through repetition. (38–39).

Passions have certainly brought innovation (the small differences) to the biomedical encounter of rural clinics, and trust has created new groups and marked the borders of networks. Remittance clinics proliferate within their social milieu, but this does not mean that they can infinitely be reproduced. I argue that these markets are not infinite and are not easily transferable or translatable into other spaces. Remittance clinics are specifically situated, they make the space and are made by the space in which they emerge.

Conclusion

To say that the work remittances and medicine do in remittance clinics is to make relatives, now seems obvious. How could remittance clinics not be about bringing relatives into being if the most evident role of remittances is to care for families? This was not evident at the beginning of writing this dissertation, however. It took writing three chapters to start seeing what remittances and medicine were doing. The main contribution of this dissertation has come as a complete surprise. In the first attempts to think through my ethnographic material, medicine in rural El Salvador was just culturally different than medicine elsewhere, and as such, medical practices were incommensurable to other sites. The cultural significance of injections, drug quantity, and drug intensity explained what was different in these clinics. Once I started examining remittances and medicine as actors, as doers, as makers, the dynamic processes of the clinics and of remittances opened up. The bulk of the dissertation has dealt with how medical interactions and practices participate in the process of making relatives when remittances are involved. Said this way, remittances remain partly unexamined, part of their quality remains assumed. In what follows, I reflect further on the ways that thinking about remittances in terms of their ability to make relatives shows the edges of remittance networks and flows.

Remittances have gained undisputed importance in the economy of El Salvador.[15] Today, all economic reports communicating the status of the economy include inflows of remittances, sometimes compared to other economic indicators to show their relative importance. The Banco Central de Reserva (BCR, Central Reserve Bank) reports monthly total tallies and percentage changes in press releases, and conducts periodic surveys to get information on cash transfers to more accurately calculate total transfers. The BCR counts remittances not only to understand their economic impact and importance relative to other economic categories, but to demonstrate they are "long-term and structural," which means "this flow of wealth could be 'securitized,' bought and sold profitably as

15. How remittances have been made such a seemingly fundamental, determinant, and permanent fixture of Salvadoran life is a fascinating story beyond the interest of this dissertation. I have been more concerned with the doings of remittances once already made important.

a financial instrument" (Pedersen 2013, 50). In this way, Pedersen argues, they have become "interest-bearing capital," capable of being turned into money-producing money. Financial institutions disseminate monthly totals and percent changes as indicators of economic "health," along with unemployment, payroll, and export reports.

Remittances have become legitimate "interest-bearing capital" at the macro level, and legitimate income at the individual one. As I arrived in El Salvador to begin my 12-month stay for fieldwork, I wanted post-paid mobile service because it offered better rates than the popular pre-paid service. But since I did not have a credit score established I did not qualify. After a moment of thinking, the salesperson quickly asked if I received remittances, when I said yes, he filled the "occupation" field in the application form with "student, remittance recipient." He did not ask more questions about the security of my payments. Remittances guaranteed my payments. Remittances stand in for credit scores at the individual level, and contribute to better scores at the national level, increasing access to credit, and eventually, according to the mantra of capitalism, to growth and development. Remittances have come to be synonymous with income and growth, even when economists blame economic slowdown on the over consumption of remittance recipients. Their potential is only a matter of how to transform them into investments, not of whether remittances can produce growth.

The money transfers Salvadorans send may indeed turn into incomes, which may turn into credit lines or health, but this process is not detached from the relations that make them possible. In fact, their circulation is determined by the ability of remittances to make those relations. The remittances of Salvadorans are not too different from the money flows of a Cameroonian businessman, and Hageners, from the Highlands of Papua New Guinea described by Strathern (1996) in "Cutting the Network." Salvadorans send remittances to *nurture* their families, especially their children, parents, and grandparents. Remittances are also sent to aunts, uncles, cousins, godchildren, and many other relatives. But most of them are sent to mothers and wives. Money transfers provide food, shelter, education, clothing, mobile phones, and yes, also leisure. But before it is turned into any of these things, it comes to the mother or wife. It is first "contained," as Strathern would say, in

the *person*. These Salvadoran remittance recipients, like the Hagener women seem to be "the repository of nurture from her kin which she contains" (Strathern 1996, 517). It is the Salvadoran mother or wife that is the "repository of nurture," the "store of wealth," and others, like the doctors or pharmacist, the ones who "benefit from their relations through her" (518). In order for the doctor to benefit from remittances he must establish a relation with her. The mother, as the "container" of money transfers, "contains" the possibility of converting nurture into other goods, services, credit lines, and perhaps growth. She is the "store" in the analogy drawn by Strathern. This frame reversal, from thinking that it is her person who is the "store" rather than the pharmacy or the clinic, shifts the focus to the mother as the one that proliferates relations. It is others who benefit *through* her, not her who benefits from others.

The mother is the one that proliferates relations—she goes to the clinic, pharmacist, butcher, cheesemaker, internet cafe, mobile service provider, bank. She may stop going to the fields and start going to the tortilla maker, egg seller, and bean producer. Some relations end, new ones start. These are the proliferations of consumer markets that economists celebrate and complain about. But in the economic idiom of remittance-led development, the proliferation of remittance markers does not pass *through* the mother—clinics proliferate and mothers come. In the picture I am trying to draw, mothers proliferate relations with doctors and pharmacists, they are the "stores," others benefit *through* them. Something interesting happens in this benefiting *through* the mothers. The reproduction of clinics does not occur only to satisfy the health needs of the mother. In the rural clinics proliferated by mothers receiving remittances I observed, the "nurture from her kin which she contains" must also be materialized in the exchange. It is materialized in her person of course—she contains the money transfer—but I argue that the sender must also be materialized. The health network she expanded, gets cut when the "nurture of her kin," the sender, cannot materialize in the exchange. "Nurture" in my example, cannot be only contained in the mother; it is nurture when it is sent and transformed into goods and services. The relations she has created that expand her health network, reduce when these relations cannot materialize the sender *and* the action of sending—both make the

nurturing. The sender is also contained within the mother, and must be able to emerge in the exchange with the doctor for the exchange to occur.

I suggest that health tourism projects have repeatedly failed because the medicine they build does not allow remittances to be processes of making relatives, and thus, cannot create new networks of remittances when these are sent to create relatives. For health tourism projects, remittances are only multipliers, they are only "interest-bearing capital," capable of securing loans, granting funding, modernizing facilities, expanding services, inventing new health goods. But when remittances cannot operate to make relatives, they do not multiply. They stop flowing.

There is another way Strathern's "Cutting the Network" has helped me think about the limits of remittance networks. In her conclusion after analyzing different examples of how wealth is passed on in Melanesian kinship systems at birth and marriage, she reflects, "[kinship] Networks become measurable. They are measured by people's indebtedness to one another through the flow of objects, human and nonhuman." The Salvadoran remittance example is far from the kinship networks of Melanesia, and I do not mean to abstract either the Melanesian example nor the Salvadoran one to say that in conclusion all is the same. But the way she chooses to speak about indebtedness as a form of measurement of kinship chains, inspires me to think further about what remittances as forms of obligations do in the Salvadoran case. The kinds of obligations that instantiate money transfers is one of the big black holes of this dissertation. Family obligations and kinship making was not in my mind when I did fieldwork. I cannot give a detailed account in the fashion of anthropological kinship models of how remittances build those networks. But I have been able to discern that remittances do draw chains that do not flow endlessly. Remittances are not given based on blood only, they respond to obligations and the emotional ties that go with them. Perhaps I may want to use a term to differentiate between "blood relatives" and "remittances relatives," since remittances do not always go to blood relatives. The 'mother' I have referred to above is not necessarily a blood relative, she is defined as a relative in terms of obligations that are manifested in remittances. At the pharmacy a woman unable to speak due to what seemed to be a growth that was

taking over her nose, begged for change. I was surprised to see a beggar in this small town. There were others, mostly older men in various states of abandonment. Niña Gloria, the pharmacist who often allowed one man in particular to seek shelter on her porch, told me that the children of the woman begging were in the US, but none sent any money. She implied she had not been a "good" mother. José, in section 2.3, receives remittances only from the daughters that migrated with his finances. The daughter whose trip was financed by her husband, does not send remittances. Remittances create kinship networks that can be measured, that make clear who belongs and who doesn't. These do not proliferate endlessly, they grow in defined ways. This is another way in which remittance circulations follow certain paths, which do not always intersect with medical tourism or the growth impregnating the statistics of the BCR.

I must clarify I am not saying obligations to kin interfere with commerce, escape the capture of capitalism, or are "clean" of the wrong-doings of developmentalist exploitation. On the contrary, obligations to kin proliferate transactions and consumer markets. Remittances have created an entire market of health services, most visible through the remittance clinics and small hospitals in rural towns. My point has been that the medical practices inflected by the nurturing contained in the mother make medical realities, patients, and doctors particular to the demands of such exchange. Furthermore, the absence of these obligations, reduces commercial transactions. Perhaps the Salvadoran remittance clinic example can also serve to show that the affective relations of kin are not materially different from the flux of economic life, the opposite of what usually is expected in a Euro-American bilateral system of kinship (Strathern 1996, 531). On the contrary, they are very much part of markets, incomes, piggy banks, credit scores, and credit lines.

Much of the scholarship on remittances in El Salvador makes the distinction between the economic importance and the sociocultural importance of remittances. For example, Huezo Mixco (2009) opens his examination of Salvadoran transnational life by noting the importance of remittances is not only economic—"las remesas son, [...] expresión de relaciones sociales y emocionales" [remittances are expressions of social and emotional relations] (10). They have come to have an important role in the social fabric of family

life and the country at large. Miguel Huezo Mixco, an ex-guerilla turned poet and novelist by night and UNDP staffer by day, notes the important role remittances play in social and emotional relations when he says,

> Si bien los vínculos emocionales entre los salvadoreños en Estados Unidos y El Salvador se establecieron *antes* que los envíos de dinero —de hecho, son esos lazos culturales los que hacen posible el envío de dinero— es indudable que este juega un papel importante en esas relaciones.
>
> [Although emotional ties between Salvadorans in the US and El Salvador have been established *before* money transfers —in fact, it is those cultural ties that make possible money transfers— they undoubtedly play an important role in those relations.] (my emphasis Huezo Mixco 2009, 10).

For him the importance of remittances rests on their ability to maintain, sustain, or otherwise continue the social and emotional relations established *before* they are sent. According to this logic, relatives send remittances to maintain social ties, not to make them. This dissertation proposes that remittances actually make social ties, not just maintain them. This distinction is not just rhetorical. The distinction lies on the function of the transfer of wealth, or in this case the expenditure in health. It is the difference between saying "I send to you because you are my relative," and saying "Because I send to you, you are my relative." In the latter, remittances make the relation. This idea is not new, scholars, like Strathern, who have studied kinship networks in the South Pacific have already said it.

I hope that the sense of speculation that I have written this dissertation with has been felt. I have not tried to contribute a definite account of medical remittances, or produce a framework to know what Salvadorans do with their remittances, or to know what they are sick with. My contribution has been speculative: what if we think that medicine is an actor, what happens then? What if we think that a mother asks medicine to *make* her children, what happens then? The abstraction to think of medicine, technologies, relatives, diagnosis, and spaces as actors and practices has helped me make the remittance clinic strange enough to rethink the common sense of the ubiquity and universality of biomedical practices and knowledge. A rich specificity emerged, telling other stories of health and healing, obligations and emotions, nurture and commerce.

I have written about what happens in the remittance clinics with a sense of surprise that continues to stay with me. While I find what I have written strange, I also find it incredibly familiar. As I have presented the material in this dissertation in conferences and talked about it over dinner conversations with friends and colleagues, I continue to be surprised by how common is what I've described. For Latin Americans and others who share long histories of migration and separation, sending money to the old and young, and consulting over the phone with doctors recommended by the community they help maintain, seems to be the most common of actions. In the middle of my stories people excitedly interrupt and say, "Oh, I do that too!" My siblings and I do it too. But the ways we are engaged in obligations, indebtedness, and emotional ties, escapes us. We rather think that we do it for "love." After this dissertation, however, I can no longer think that love is that simple.

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