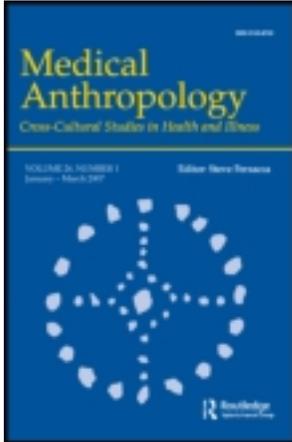


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## Structural Vulnerability and Health: Latino Migrant Laborers in the United States

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## INTRODUCTION

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# Structural Vulnerability and Health: Latino Migrant Laborers in the United States

James Quesada, Laurie Kain Hart, and Philippe Bourgois

Latino immigrants in the United States constitute a paradigmatic case of a population group subject to structural violence. Their subordinated location in the global economy and their culturally depreciated status in the United States are exacerbated by legal persecution. *Medical Anthropology*, Volume 30, Numbers 4 and 5, include a series of ethnographic analyses of the processes that render undocumented Latino immigrants structurally vulnerable to ill health. We hope to extend the social science concept of “structural vulnerability”

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to make it a useful concept for health care. Defined as a positionality that imposes physical/emotional suffering on specific population groups and individuals in patterned ways, structural vulnerability is a product of class-based economic exploitation and cultural, gender/sexual, and racialized discrimination, as well as complementary processes of depreciated subjectivity formation. A good-enough medicalized recognition of the condition of structural vulnerability offers a tool for developing practical therapeutic resources. It also facilitates political alternatives to the punitive neoliberal policies and discourses of individual unworthiness that have become increasingly dominant in the United States since the 1980s.

*Key Words:* citizenship; Hispanic health outcomes; immigrants; social inequality; social medicine; structural violence

The embattled passage of health care legislation in the United States in 2010, founded on a rhetoric of “health care for all,” expressly barred undocumented immigrants from accessing coverage, officially reaffirming their exclusion from public services and basic legal rights. At the same time, increased enforcement of immigration laws has exacerbated personal insecurity, labor market discrimination, and residential segregation (Gradstein and Schiff 2006; Canales 2007). Most importantly from a health perspective, this kind of systemic social marginalization inflicts pain (Eisenberger, Liberman, and Williams 2003).

Explicit political exclusion is one of the more visible manifestations of what has been called structural violence in social science analysis. Latino migrant laborers are a population especially vulnerable to structural violence because their economic location in the lowest rungs of the US labor market is conjoined with overt xenophobia, ethnic discrimination, and scapegoating. Simultaneously perceived as unfair competitors in a limited-good economy (Foster 1965; Quesada 1999) and freeloaders on the shrinking welfare safety net (Cockcroft 1986; Gómez-Quíñones 1994; Gutiérrez 1995; Mahler 1995; Coutin 2000; De Genova 2004), they are subjected to a conjunction of economic exploitation and cultural insult (Bourgois 1988).

The term structural violence is generally attributed to the sociologist Johan Galtung (1969). Arguing for a social-democratic commitment to universal human rights, in the face of US Cold War blindness to the political effects of third-world poverty and the legacy of colonial inequity, Galtung defined structural violence as “the indirect violence built into repressive social orders creating enormous differences between potential and actual human self-realization” (Galtung 1975:173). He specifically differentiated structural violence from institutional violence, emphasizing the former’s “more abstract nature . . . that can [not] be traced down to a particular institution” (Galtung 1975:173, 175).

The theorization of structural violence also has radical roots in anticolonial resistance movements (Fanon 1963) and in Catholic liberation theology's advocacy for a "preferential option for the poor" (Camara 1971; Martin-Baro, Aron, and Corne 1994). In medical anthropology the term has been used to highlight disparities and to identify socially structured patterns of distress and disease across population groups, from mental health, occupational health, and interpersonal/domestic violence, to infant mortality, substance abuse, and infectious diseases (Galtung 1969; Martin-Baro et al.; Scheper-Hughes 1996; Kleinman 2000; Parker, Easton, and Klein 2000; Bourgois 2001; Pedersen 2002; Farmer 2004; Walter, Bourgois, and Loinaz 2004; Heggenhougen 2005). The infectious disease physician and anthropologist Paul Farmer (2003) has made structural violence the centerpiece of his argument that access to health care is a fundamental human right.

Many analyses of structural violence have included cultural factors such as gender inequality and racism. Nevertheless, in practice the concept has been used primarily to invoke materialist forces calling attention to class oppression and economic injustice. The semantic tension in the phrase effectively conveys the urgency of its analytical point and mobilizes political, ethical, and practical engagement: it rhetorically juxtaposes the morally evocative and physically concrete word "violence" with the abstract and ostensibly neutral word "structure." However, the term's political and humanitarian valence—especially in its Latin American manifestation as liberation theology in solidarity with armed revolutionary struggles—alienates some critics. Other scholars object to the purposefully provocative broadening of the concept of violence into a political-economic abstraction.

The more neutral and inclusive term "vulnerability" may be useful, consequently, to extend the economic, material, and political insights of structural violence to encompass more explicitly (and to project to a wider audience) not only political-economic but also cultural and idiosyncratic sources of physical and psychodynamic distress. These include (1) social hierarchies buttressed by symbolic taxonomies of worthiness (Bourdieu 2000); (2) historically distinctive discourses of normativity and ethics (Foucault 1984); and (3) the intersection of individual medical pathology and biography with social exclusion (Biehl 2005). In our conceptualization, structural vulnerability is a positionality. The vulnerability of an individual is produced by his or her location in a hierarchical social order and its diverse networks of power relationships and effects (Leatherman 2005; Watts and Bohle 1993). Individuals are structurally vulnerable when they are subject to structural violence in its broadest conceptualization. This includes the interface of their personal attributes—such as appearance, affect, and cognitive status—with cultural values and institutional structures.

Economically exploited and politically subordinated individuals and collectivities often internalize their externally generated depreciated status in a complex and poorly understood process of embodiment that shapes their behaviors, practices, and self-conceptions—their “habitus” (Bourdieu 2000) or their “subjectivities” (Foucault 1978, 1995; see Butler 1997:86; Biehl, Good, and Kleinman 2007; Pine 2008:12–14, 17; Bourgois and Schonberg 2009:18–19). This embodiment of subordinated status produces a form of symbolic violence whereby the everyday violence of imposed scarcity and insecurity is understood as natural and deserved (Bourdieu 2000; for ethnographic accounts of the negative effects of symbolic violence on health, see Bourgois, Prince, and Moss 2004; Pine; Auyero and Swistun 2009). Ill health under these conditions, as Nguyen and Peschard argued (2003), can be conceptualized as the outcome of forms of violence sustained by political-economic and cultural rationales, and can be managed through historically specific modes of governmentality in a social milieu and political context of marked indifference to the afflicted.

Structural vulnerability implies a critique of the concept of agency because it requires an analysis of the forces that constrain decision making, frame choices, and limit life options (for a rejection of the agency-structure polarity through the concept of habitus and “practice,” see Bourdieu and Wacquant 1992; Calhoun, LiPuma, and Postone 1993; see also Bourgois and Hart 2010). It identifies “spaces that configure a specific set of conditions in which people live, and set constraints on how these conditions are perceived, how goals are prioritized, what sorts of actions and responses might seem appropriate, and which ones are possible” (Leatherman 2005:53). When translated into health care practice, the concept of structural vulnerability can become a productive tool for contextualizing diagnosis and informing critical praxis (Singer 1995; Delor and Hubert 2000). Demystifying agency and removing the moral judgment inherent to a theoretical concept that implies that individuals understand and control the consequences of their everyday actions can contribute to rectifying the misdiagnosis, blame, and maltreatment that accompany the experience of poverty and cultural subordination. This is especially important in a society like the United States, which individualizes responsibility for survival and relies on an ideology of free market forces to distribute goods, services, and health to the disenfranchised.

## THE CRITIQUE OF RISK IN PUBLIC HEALTH AND MEDICINE

Conventional public health interventions primarily target individuals by promoting behavior change through imparting knowledge, skills, motivation, and/or “empowerment” based on a cognitive model of rational

choice theory in medical decision-making. There is a growing recognition in the field of public health and medicine, however, of the ways social inequality imposes “risk” on subordinated population groups. This involves an awareness that a larger “risk environment” precedes individual decision-making (Rhodes 2002), but, significantly, there is not yet a logically consistent conceptual vocabulary or analytical approach to the definition of the risk environment in public health and medicine. Critical public health approaches propose a broad range of overlapping terms for grappling with the effects of social inequality, including, among others: “social epidemiology” (Poundstone, Strathdee, and Celentano 2004; Diez Roux 2007; Galea, Hall, and Kaplan 2009), the “eco-social” or “socio-environmental perspective” (Brown and Inhorn 1990; Krieger 1994, 2001; Richard, Potvin, and Mansi 1998; Burris et al. 2004), “eco-epidemiology” (Susser 1996), and the “the risk environment framework” (Rhodes and Simic 2005; Rhodes 2009; also see review by Strathdee et al. 2010). They call for a focus on “fundamental social causes” (Link and Phelan 1996, 2002), “social determinants of health inequality” (Strathdee et al. 1997; Kawachi and Kennedy 1999; Marmot 2005; Marmot and Wilkinson 2006), “income inequality” (Kawachi and Kennedy), “political and economic determinants” (Singer 2001; Navarro and Muntaner 2004), “conjugated oppression” and “hierarchies of embodied suffering” (Holmes 2007), “zones of abandonment” (Biehl 2005), “higher order causal level structural factors” (Miller and Neaigus 2001), and “discrimination” and “racial disparities in health outcomes” (Marmot, Shipley, and Rose 1984; Lillie-Blanton and Laveist 1996; Williams 1999; Ferrie et al. 2003; Smedley, Stith, Nelson and Institute of Medicine 2003; see also review of race and inequality in the public health literature by Krieger 1999).

Within the field of HIV prevention studies, the risk environment framework has been especially productive (Sweat and Denison 1995; Parker et al. 2000; see review by Rhodes 2009). This perspective allows for an ethnographically concrete focus on social inequality at the local level that does not individualize risk. It invokes processes and factors such as “urban desertification” (Wallace 1990), “social and structural violence” (Shannon, Kerr et al. 2008), “syndemics” (Singer and Clair 2003), “neighborhood effects” (Latkin et al. 2005; Maas et al. 2007), “grey zones” and “politically structured suffering” (Bourgois and Schonberg 2009), “neighborhood socio-economic status” (Williams and Latkin 2007), “enabling environments” (Moore and Dietze 2005), “residential segregation” (Cooper et al. 2007), “environmental-structural barriers” (Shannon, Rusch et al. 2008), “structures and dynamics of drug-using networks” (Friedman et al. 1999, 2000), and “big [historical] events” and “destabilization pathways” (Friedman, Rossi, and Braine 2009). It argues for the need to develop “structural approaches to prevention” (Bourgois 2008; Gupta et al. 2008).

Nevertheless, despite calls for addressing the effect of social inequalities on health, and despite impressive documentation and meta-analysis of epidemiological associations between structural forces and the prevalence of premature death and illness burden (cf. Krieger 2008; Friedman 2009; Rhodes), the conventional biomedical paradigm largely fails to translate the documentation of social forces into everyday practice and epistemology. In the absence of clinically accessible effective alternative models, clinicians continue to treat individual patients primarily in a psychological, social, cultural, and class vacuum. Public health interventions continue to focus primarily on changing the micro-behaviors of individuals through knowledge-based education interventions, based on middle class models of rational choice decision-making.

In medical anthropology, the concept of structural vulnerability focuses on how a host of mutually reinforcing insults (ranging from the economic and political to the cultural and psychodynamic) that dispose individuals and communities toward ill health are embodied. We use the term “insults” because it brings from a disease etiology model a focus on the interactions between an individual or group and an environment. An insult is a physical, chemical, infectious, psychological, or social-cultural stimulus that adversely affects an individual, group, or community in dynamic relation to an environment (Audy 1971; Brown and Inhorn 1990). Health and disease are states indicative of an individual’s relationship to an environment, given that, as Brown and Inhorn argued, “exposure to a pathogen [is] a necessary but not sufficient cause of disease . . . the progression from exposure to disease depend[s] in part on the health of the exposed person, in which . . . an individual’s vulnerability to a complex of insults, is never constant” (1997:39). This approach requires, then, a dynamic ethnographic tracking at the level of both individual biography and social/physical-environmental context.

### ANTHROPOLOGICAL APPROACHES TO THE STRUCTURAL VULNERABILITY OF UNDOCUMENTED LATINOS

The vulnerability of Latino migrants is exacerbated by their interactions as economically disenfranchised laborers in a society that regards them as criminals and devalues their individual and cultural worth. This devaluation is a routinized, lived experience shared by Latinos throughout the United States that is not confined to those lacking legal status (Chavez 2003; Willen 2007). The Latino threat narrative (Chavez 2008) has come to dominate popular thinking about Latinos and places all of them under social and emotional duress (Rosaldo 1999). Significantly, however, a sharp gradient

distinguishes the life chances of Latinos according to class, citizenship status, racialized stereotyping, and ethnic hierarchies (e.g., nationality and indigeneity.) By implicating social conditions, structural vulnerability attends closely to those variables and critiques the conceptualization of Latino migrants as an at risk population in which individuals engage in risky practices with an accompanying connotation of individual and collective/cultural guilt (Hernandez-Rosete Martinez et al. 2005; Rocha 2006). As Bronfman and colleagues noted, “While risk points to a probability and evokes an individual behavior, vulnerability is an indicator of inequity and social inequality and demands responses in the sphere of the social and political structure. It is considered that vulnerability determines the differential risks and should therefore be what is acted upon” (Bronfman, Levy, and Negroni 2002:483). Our qualification here is that vulnerability must be addressed not only in the political domain but also in the clinical encounter.

Invoking the concept of structural forces has analytical limitations in clinical and practical service-providing contexts because of its inherent abstraction (Scheper-Hughes and Bourgois 2004; Wacquant 2004). Nevertheless, anthropology’s participant-observation methods can make an abstract concept come alive through thick description—in the case of this collection of articles (Volume 30, Numbers 4 and 5), through a focus on the relationship between undocumented Latino experiences of social inequality and health. Ethnographic analysis can open the black box of embodiment and subjectivity formation. Anthropological approaches to health through the lens of structural forces can document highly localized practices and provide a comparative perspective on how specific policies and institutional processes affect individual health experience and larger disease patterns (Parker et al. 2000:S29–S30). This theoretically informed documentation of the larger contexts for intimate suffering can facilitate the design and implementation of upstream structural interventions that improve health outcomes. These interventions do not inevitably require those who are benefitted to change individual behaviors or, if behavioral change is involved, to be conscious of why such changes are affecting health outcomes: let us remember that improvements in urban sanitation in nineteenth century London had the most significant impact on the public’s health in that era.

Furthermore, because of the sensitivity of health practitioners to the clinical case study as a paradigm of pedagogy and knowledge-creation, anthropological methods and in particular the medium of “thick description” (Geertz 1973) can resonate with clinicians on the front lines. Medical anthropology’s attendance to narratives that move beyond standard medical history-taking can be useful. Similarly, life history approaches that explore the practices that shape the experience of distress and illness (Kleinman,

Das, and Lock 1997) and examine the “wanted and unwanted experiential conditions of self” (Hahn 1995) may offer productive practical insights for health care practitioners. In short, the combination in critical medical anthropology of participant observation methods and humanities and social science theory facilitates a theoretical/practical interpretation of structural vulnerability that extends beyond linear economic forces and addresses the embodiment of discursive, symbolic, and psychodynamic effects of power (Singer and Baer 1995a; Kleinman et al.; Bourdieu 1999; Briggs and Mantini-Briggs 2003; Scheper-Hughes and Bourgois 2004; Gutman 2007). It also, importantly, constitutes an approach highly compatible with the clinical sensibility of learning from case presentations of patients in distress and pain.

Structural vulnerability is not unique to Latino migrants in the United States. It applies to the poor, the medically uninsured, the sexually stigmatized, people of color, the disabled, the incarcerated, and those with drug and alcohol problems. Experiences of vulnerability, however, are only partially shared across populations because they are shaped unevenly by specific status attributes (i.e., gender, age, ethnicity, etc.), conditions (i.e., legal status, economic and living conditions, etc.), and individual serendipity. In this collection, we have focused on Latino migrants because of an increasingly xenophobic socio-political atmosphere, intensified in the aftermath of the bombing of the World Trade Towers and the declaration of the War on Terror (Johnson 2004). These historical, global factors have rendered Latino migrants especially visible as an outsider ethnic group subject to moral judgment in the United States (Heyman 2000; Bender 2002). Furthermore, undocumented Latino laborers who take action by crossing the border extra-legally—by any means necessary—are paradigmatic for illustrating the complex interactions between North/South inequality and individual strategic determination to survive/improve life chances in the increasingly competitively polarized globalized economy (Hernandez-Rosete Martinez et al. 2005).

Latino immigrants occupy a disjunctive liminal quasi-caste status in the United States (Sandesara 2008). They are stereotypically presumed to be excluded from the entitlements of citizenship. In this new era of “post-racial” racism (Jackson 2008), xenophobia is disguised as concern with national security, the fiscal consequences of population pressure on local governments, euphemized crises of moral turpitude and criminality, and threats to national cultural cohesion. A dramatic example of this was the passage of the Arizona Senate bill in 2010 authorizing the police to arrest any individual suspected of being undocumented on the basis of appearance without the standard US constitutional prerequisite of “probable cause.” Citizenship status determines access to social and health care services in the United States despite international conventions and

consensus that immigrants and migrants should retain basic human rights that are legally and morally located beyond the nation state. Outside the United States, distinct definitions and legal criteria of belonging provide opportunities for non-citizens to access basic care and treatment (Fassin 2001; Fassin and D'Halluin 2005; Ticktin 2006). For example, despite France's racist/stigmatizing biopolitics of otherness, migrants in France are accorded medical rights consistent with a humanitarian-universalist approach to the suffering body. They are not only granted care and treatment but also, in many cases, residency on the basis of their special medical needs (Fassin). The same does not obtain to suffering immigrant bodies in the United States. In fact, bearing the diagnosis of a serious medical condition is one of the official Immigration and Naturalization Service (INS) bureaucratic categories for denying visas to tourists and legal residency status to immigrants (Costich 2001; Ruiz-Casares et al. 2010).

The dynamics of social exclusion and the limits placed on citizenship play out on streets and in fields, homes, and clinics in the form of economic scarcity, food insecurity and hunger, exclusion from care, and restrictions on the professional autonomy of health providers. Ultimately, the larger public's health is endangered. Denial of care and treatment to some threatens the general health and well-being of all (Farmer 2010). This threat to the well-being of the public does not derive from the fact that migrants are potential disease vectors (as nativist discourse insistently claims) but from the structural reality that a whole sector of the population is being "adversely incorporated" (Kullgren 2003; Du Toit 2004; Hadley et al. 2008), undermining the foundation of the low-wage labor market and undercutting the general standard of living of the poor.

Immigration, both voluntary and involuntary, raises deeply contentious questions of belonging. Citizenship, when narrowly defined in strictly nationalist terms, produces a multi-tiered human-rights regime in which state biopower (Foucault 1978) promotes the health of some rights-bearing citizens while reducing illegal immigrant bodies to the status of "bare life" (Agamben 1998)—populations both devoid of rights and subject to the repressive power of the state (see Nikolopoulou on Agamben's critique of the "slippage from 'man [*sic*]' to '[national] citizen'" in the French Revolution's Declaration of the Rights of Man and Citizen 2000:128, 131). Homeland Security detention centers are a prime contemporary manifestation of the phenomenon of the state-administered "camp" described critically by Agamben as imposing and enabling repressive and arbitrary discretionary power on legally excluded populations (cf. Heyman 1998):

The stadium in Bari into which the Italian police provisionally herded all illegal Albanian immigrants in 1991 before sending them back to their country,

the cycle-racing track in which the Vichy authorities rounded up the Jews before handing them over to the Germans, . . . the refugee camp near the Spanish border where Antonnio Machado died in 1939, as well as the *zones d'attentes* in French international airports in which foreigners requesting refugee status are detained will all have to be considered camps. In all these cases, an apparently anodyne place . . . delimits instead a space in which, for all intents and purposes, the normal rule of law is suspended and in which the fact that atrocities may or may not be committed does not depend on the law, but rather on the civility and ethical sense of the police that act temporarily as sovereign. (Agamben 2000:174; see Heyman 2000 for an ethnographic account of the discretionary margin for moral decision-making according to INS border agents)

### THE VULNERABILITY OF LATINO LABORERS IN HISTORICAL PERSPECTIVE

Latino migration to the United States is driven by a combination of historically embedded market forces that have made subsistence survival difficult in sending countries. At the same time, political coercion in the receiving country maintains artificially low labor costs and exceptionally high labor discipline (Burawoy 1976; Walter et al. 2004). Latinos in US society have been systematically deprived of equal rights as citizens since the Mexican American War in 1848 (Weber 1973). A contradictory dualism underlies the laws and populist nationalist sentiments that structure the conditions for undocumented workers. Throughout the twentieth century, public policy has waxed and waned between repression and tolerance in response to economic cycles and political exigencies. Mexican labor entered the United States unrestrained until the Great Depression when Mexicans were forcibly repatriated (Andreas 2000). Mexicans were then recruited during World War II labor shortages under a regulatory “Bracero program” regime. Nevertheless, nation-origin quota systems effectively excluded immigrants from Latin America, Asia, Africa, and Southern Europe until 1965, when the Hart-Cellar Act passed by Congress eliminated the quota system and replaced it with a system of numerical totals for each hemisphere with preferences for family reunification and labor priorities. Amendments in 1978 removed hemispheric ceilings, imposing instead a combined global total immigration quota. Since then Latino migration has gone through several waves (Massey, Durand, and Malone 2002), with the latest wave that accelerated from the 1990s to the 2010s representing the fallout from economic and social dislocations caused by the implementation of the 1994 North American Free Trade Act and the 2008 Central American Free Trade Agreement (Andreas 2000; Bacon 2008; Quesada 2009). The exploitative relationships linking foreign trade and political and economic policies

toward Latin America to undocumented immigration have been officially obfuscated (Bustamante 1998) and barely register in the popular imagination. The politically imposed economic forces that generate undocumented migration from Latin America to the United States remain largely invisible in the news media despite considerable coverage of violent local reactions against the presence of Latinos in rural and suburban communities.

Neoliberal free trade agreements and policies have undermined the traditional subsistence agricultural communities, small-scale manufacturing, and the artisanal and mercantile local firms that provide wage employment in the cities and countryside in the non-industrialized world (Harvey 2005; Klein 2007; Quesada 2009). Economically and socially unmoored, with viable income-generating alternatives constricted, displaced workers have crossed borders to seek survival opportunities throughout the Americas. Those who have made it to North America predominate in dangerous low-wage jobs in construction, sweat shops, agriculture, and service industries: they tolerate wages and working conditions unacceptable to most native-born workers. Repeating earlier scenarios of US labor conflicts that exacerbated racism (e.g., the importation of blacks from the South as strike-breakers in northern industry following World War I), native-born US workers are susceptible to immigrant-bashing discourses (Feagin 1997). They do not make the political-economic connections that would allow them to recognize how overseas corporate investments, large agribusiness penetration in Latin America, and the establishment of *maquiladoras* (duty-free and tariff-free assembly or manufacturing factories), promoted by international lending institutions and foreign aid policies, compel emigration.

### STRUCTURAL VULNERABILITY IN GOOD-ENOUGH CLINICAL AND PUBLIC HEALTH PRACTICE

Emphasizing the importance of structural vulnerability for the basic lexicon of our larger subdiscipline is only a first step for critical medical anthropology. The recent history of the use of the concept of culture in medical pedagogy and in clinics provides a good illustration of the perils and potentials of translating anthropological theory into health care practice. Beginning in the mid-1970s, medical anthropologists contributed to the recognition by clinicians of the cultural barriers to effective health care. This ultimately filtered into the practice of medicine through the rubric of “cultural competence,” which was formally institutionalized in medical school curricula in 2001 as a required field for licensing in the United States by the Liaison Committee on Medical Education. The culture concept, however,

has long been recognized as problematic within anthropology (Weiner 1995; Marcus and Fischer 1999; Visweswaran 2010), and its practical application can easily devolve into a repackaging of stereotypes that essentialize the very populations targeted as requiring special attention. More trivially, in the clinic, so-called cultural competence is often relegated to etiquette, a question of bedside manners, or techniques to improve compliance and assert authority. Critical medical anthropology, consequently, has criticized the pedagogical cure for cultural incompetence as being worse than the disease (Good et al. 2002).

'Structure,' like the term culture, can obscure as much as it elucidates; nevertheless, structural vulnerability as a concept for medical practice may counteract the essentialization plugging notions of culture. Instead of emphasizing the incommensurability and sui generis explanatory power of diversity, structural vulnerability points to the sources and effects of social inequality that can be ameliorated with political will and appropriate allocations of resources, technology, and legislative oversight. Already some medical schools have instituted curricula to address "socially vulnerable populations" (King and Wheeler 2007) that go far beyond the scope of cultural competence. In addition to the traditional course format, these curricula include home visits with required fieldnote-taking, socially themed grand round lectures, and the integration of "attending anthropologists" into the pedagogical clinical teams that lead case conference presentations.

Despite the political limits and contradictions of practicing applied anthropology in the clinical setting (Scheper-Hughes 1990; Kleinman 1995; Singer and Baer 1995b), we need to respond to critical medical anthropology's challenge to move beyond the academy and to propose practical interventions that have immediate consequences (Singer 1995). All diagnostic tools inherently present the danger of reification, and there is an epistemological contradiction between anthropology's commitment to revealing the causal complexity (overdetermination) of human behavior and the practical exigencies of service provision. Nevertheless, we envision that an important clinical translation of structural vulnerability might take the form of screening protocols that could be administered in medical care settings. Clinical service providers operate under intense time constraints and routinely rely on checklists to flag diagnoses of frequently overlooked complex conditions such as depression, child abuse, addiction, etc. Structural vulnerability checklists developed in a collaboration between clinicians from the various medical disciplines/specialties and anthropologists could (1) open the medical gaze toward an awareness of the embodied effects of social positioning, (2) legitimize through evidence-based practice the allocation of increased resources (medical, social service, and political) to the

disenfranchised, and (3) improve the quality of care for the poor. Structural vulnerability does not constitute a diagnosis; it serves to alert the health care provider to the potential need for pursuing a wider range of diagnoses and for targeting resources. This approach can help to identify and overcome the barriers to adherence that are often clinically invisible and tend to be misattributed to the self-destructive will of the patient. Improving outcomes and recognizing the external, systemic causes for failures may be especially helpful to counter the problem of service provider burnout and of negative clinical interactions (as described, for example, by Holmes, this volume, in the occupational health clinics serving indigenous migrant farm workers).

It is not solely a matter of training and sensitizing individual health practitioners to see their patients as structurally vulnerable but also a question of establishing viable institutional practices that encourage health practitioners to fulfill their roles as genuine healers. Insisting that both health practitioners and the systems they work within include structural vulnerability as an etiologic agent in the presenting signs and symptoms that they confront daily pushes medicine to extend its purview toward becoming more fully social and more responsive to underserved populations. The emerging applied health services literature on the efficacy of compelling all levels of the clinical hierarchy to fill out short procedural lists in the intensive care unit testifies to the importance of the introduction of deceptively simple bureaucratic protocols (Haynes et al. 2009). Structural vulnerability has very real consequences: shorter lives subject to a disproportionate load of intimate suffering. Medicine is increasingly committed to a scientific discourse that defines best medical practice as based in quantitatively documented medical efficacy and evidence-based practice. There exists a large epidemiological body of literature documenting social disparities in health related to Latino migrant workers (Lara et al. 2004; Zsembik and Fennell 2005; Organista 2007; Barr 2008; Nandi et al. 2008). This literature has revealed, for example, the perplexing phenomenon of the “Latino public health paradox”—the association between deteriorating health outcomes and length of residence and increased acculturation in the United States (Prislin et al. 1988; Kaplan and Marks 1990; Balcazar and Krull 1999). If the recognition of social forces could be demonstrated through quantitative/bureaucratic documentation to have clinical efficacy—defined both as cost-effectiveness and better medical outcomes—this may facilitate a practical logic for diversifying and increasing resources for underserved populations in the contemporary neoliberal era. Furthermore, it may encourage health care practitioners to use the scientific legitimacy of medicine to take leadership outside the clinic to remedy institutional and political barriers to health (Holmes 2006; Farmer 2010).

## THE ARTICLES

All the contributors to our special series—which includes the articles in this issue (Volume 30, Number 4) and some in the issue that follows (Volume 30, Number 5)—are critical medical anthropologists who focus on both the patterned effects and the specific consequences of structural vulnerability on Latino migrants. They link the use of a structural vulnerability framework to broader political implications in the interest of advocacy and healing. The concluding two articles (in Issue 5, by Smith-Nonini; Cartwright) also address specific legal and policy interventions.

The negative effects of current labor hierarchies and processes of conjugated oppression on Latino migrants are not confined to their work world but pervade the multiple social settings in which they are embedded, including farms and clinics (Holmes; Duke); the courts, police, and homeland security regimes (Cartwright; Green; Smith-Nonini); the dwellings in which migrants live (Duke; Holmes); and the public spheres migrants traverse (Green; Quesada; Cartwright; Duke). The articles attend closely to the hostility, scorn, and violence of the dominant society that migrants routinely endure.

The recognition of structural vulnerability in clinical settings is especially important in the contemporary historical moment to counteract the rhetoric of blame that legitimizes the punitive retraction of access to health care and promotes the further criminalization of undocumented Latino immigrants despite their essential location in the functioning of the US economy. Fine-grained ethnographic accounts of individual lives in the context of the global and local forces that press on them are the foundation for a practical, wider, and more broadly disseminated understanding of the effects of structural vulnerability.

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