César Ernesto
Abadía-Barrero

Health in *Ruins*

The Capitalist Destruction of Medical Care at a Colombian Maternity Hospital

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The Capitalist Destruction of Medical Care at a Colombian Maternity Hospital

CÉSAR ERNESTO ABADÍA-BARRERO

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For Malena and Laila

For El Materno and all its people

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While one never knows the exact moment when a collaborative research endeavor can be narrated and analyzed in a book format, in the case of *Health in Ruins*, it happened as I was sitting at a Harvard Friday morning seminar by Michael Fischer. Mike told me that I should write a book about the hospital and that, if I did, I should consider his Experimental Futures series at Duke. Thank you, Mike, for years of encouragement, for engaging so deeply with this work, and for helping me understand what Latin American scholarship and El Materno's history had to say with this book.

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PROLOGUE

August 1992

I made my way off a crowded bus close to downtown Bogotá, at the corner of 10th Avenue and 1st South Street. Even though I knew it was bad for my back, I carried a heavy bag by a strap on my right shoulder, blocking the zipper with my right arm and hand to protect its contents from potential pickpockets. I knew the area was not very safe, and I worried about my dental instruments. I was in my last year of dental school, arriving at a mandatory hospital rotation at Colombia's main public hospital, *Hospital San Juan de Dios (El San Juan)*, which was affiliated with the country's main public higher education institution, the *Universidad Nacional de Colombia (La Nacional)*. Clinic started at 7:00 a.m. and we (the students in the hospital rotation) had to arrive early, before 6:40 a.m., to deliver our dental instruments to the sterilization unit so that they would be ready for our first patients. Luckily, we didn't have to bring our own dental materials (amalgam, composite resin, and so on), as was the norm in many private universities' dental school programs. In fact, the previous year, the school administration had considered this as a possibility: forcing students to bring dental materials to treat the clinic's paying patients. But the dental school students, concluding that our role as public university students was not to subsidize the dental school, initiated a series of marches; joining forces with students from other schools in a university-wide strike, we protested the university's plans to raise tuition and the government's intentions to cut the already insufficient university budget even further.

At the hospital rotation, we had the opportunity to work on multidisciplinary teams overseeing the care of patients with different medical diagnoses. We were also on call at the hospital's emergency department, where a dental unit was housed in a small office. Despite our discontent with many aspects of the school's and university's policies, we felt privileged to be learning at El San Juan, as the hospital was most commonly known. We knew that we were part of the symbiotic history of two legendary institutions (El San Juan and La Nacional) that, together, had given rise to the country's most important advances in modern medicine. Their graduates had a reputation for being the country's best clinicians; the hospital developed medical knowledge, housed the most respected professors, and saw an unrelenting stream of patients.

That particular day, I was going to rotate at the hospital's maternity ward, known as *El Materno*, where professor of dentistry Astrid Olivar stubbornly insisted that dentists were fundamental to health care provider teams in child and maternity centers. She taught dental and medical students the importance of caring for the edentulous newborn mouth and of providing oral health care to pregnant women. The maternity ward was one of the many hospital pavilions built under French medical architectural influence at the beginning of the twentieth century. Corridors with massive windows led to infirmaries where small groups of poor women from all parts of the country shared stories and beds; the hospital was always running over capacity. The massive green quad, with its walking paths connecting the maternity hospital to the general hospital and specialty clinics, had succumbed to city development planners who saw a need for connecting the disjointed north and south 10th Avenue through the quad. A tunnel and a bridge were built to keep all the San Juan buildings connected with El Materno, which was now located on the east side of 10th Avenue.

On that particular August day in 1992, I had to bring a pregnant woman from El Materno to El San Juan's dental clinic, located in another beautiful French-style pavilion that greeted visitors with an impressive, marble staircase. Rather than using the bridge to cross the busy 10th Avenue, which by that time had grown into a busy, two-way, six-lane street, I did as everybody else did: pushed the patient in a wheelchair to the traffic light and waited for the signal. It was shorter and less tiring than using the bridge.

August 2005

I was now a newly appointed professor at an anthropology department in Bogotá. Sitting at my desk, I came across yet another piece of news about El Materno: the hospital's director was strongly opposing the government's claim that El Materno's closure would not affect the health of poor pregnant women and their babies, that the region's health care network could easily make up for the maternity and neonatal beds that El Materno provided. Aware that many public hospitals had already been shut down as a result of neoliberal health reforms, I thought to myself, "It is *El Materno*'s turn." I felt a sense of rage and an urgent need to get inside the hospital and record what the closing of a major public hospital looked like. I organized a small ethnographic research protocol to inquire as to how economic precarity and the threat of closure were affecting the hospital's provision of care.

A week later, I returned to El Materno to find out the required institutional steps for overseeing and approving research protocols. As I approached the hospital, walking up 1st South Street toward 10th Avenue, it seemed that the gate leading to San Juan Hospital's dental clinic was open. Only as I drew closer did I realize that the building was in fact closed; its parking spaces were now being used as a public parking lot. All the San Juan buildings (the eighth-floor general hospital and the several other buildings hosting clinical specialties and research institutes) had been shut down since 2000. Without patients, the legendary hospital complex now stood, a ghostly symbol, testifying to the calamitous situation of the country's health. Unkempt grass, layered dust, and city smoke were stuck to the layers of paint peeling off the buildings' brick walls. Surreally, a handful of security guards protected the abandoned buildings.

The following week, I experienced the same sense of intimidation I had felt as a student at the hospital thirteen years earlier as I presented my formal research protocol to El Materno's ethics committee: two prominent School of Medicine physicians/professors and the head nurse in charge of the hospital's education programs. This time, however, I was able to expound on issues they were less familiar with than I, such as ethnography as the prime method of anthropological research and the importance of applying social science to health scenarios. As the conversation went on and the formal task of approving the research proposal transitioned into a more casual conversation, the hospital committee members and I got to the political substance of my project. I said that I wanted to provide witness to the collapsing situation of the hospital and to understand what it was like for clinicians and patients to provide and receive care during economic uncertainty and under

government threats of closure. I said that my purpose, more than anything, was to use research tools to register and synthesize data that might disrupt the deepening privatization of the country's health care network. The ethics committee shared my politicized research approach and assured me that they valued social sciences and that my work might help them with their main purpose: to remain open. I said that I was there to help them in any way I could, even if it just meant registering the hospital's evolving history.

TIMELINE: PEOPLE, INFRASTRUCTURES, AND EVENTS

1564	First religious hospital with private character, disputed as potential origin of Hospital San Juan de Dios (HSJD).
1635	Origin of HSJD as public hospital.
1810	Colombia's independence.
1828	First president, liberator Simón Bolívar, signs decree regulating El San Juan's budget reports and administerial functions.
1867	Creation of the Universidad Nacional, including its Medical School, Facultad de Medicina de la Universidad Nacional (FMUN). Law 66 elevated the medical school as the academic reagent of the Hospital San Juan de Dios.
1869	Beneficiencia de Cundinamarca (Main "Welfare Institution" of the State. Became the administrative unit in charge of hospitals). (ch. 2 and 4)
1944 (May 4)	El Materno is formally created as Instituto de Protección Materno Infantil.
1948–1958	La Violencia, decade of civil war between the liberal and conservative parties.

1953	El Materno is renamed as Instituto Materno Infantil "Concepción Villaveces de Acosta."
1955	Gabriel Lamus (ch. 2) starts pediatric residency at El Materno.
1969	Carlos Pacheco (ch. 1) passes the admission test for the FMUN.
1972	SINTRAHOSCLISAS (clinics and hospitals workers' union) is created.
1975	New Health Care System: Sistema Nacional de Salud (SNS).
1975 (May)	Medical School takes over the San Juan de Dios under Dean Guillermo Fergusson.
1976	The administration of HSJD is transferred to the Universidad Nacional.
1977	Santiago Currea starts working at El Materno. (ch. 2)
1978	President Julio César Turbay Ayala decrees the Estatuto de Seguridad (Security Statute) that unleashed a new wave of violence against leftist sectors of society.
1978/79–2005	Private Foundation San Juan de Dios administered the hospitals based on 1564 private origin of the hospital. In 2005 Colombian Council of State nullified the decrees that originated the Private Foundation and returned the public character to the hospital.
1978	Luis Carlos Méndez (ch. 1) takes admission test for FMUN.
1978	Kangaroo Care Program (KCP) is created by Edgar Rey Sanabria, director of El Materno.
1979	Carlos Pacheco starts residency in gynecology at El Materno. (ch. 4)
1979	Héctor Martínez starts to run the KCP.
1981	Gabriel Navarrete starts to run the KCP.

1982	Carlos Pacheco finishes residency and is hired as gynecologist at El Materno.
1983	Edgar Rey and Héctor Martínez publish the first results of KCP.
1982–1984	El Materno is remodeled.
1984	The Universidad Nacional is closed for a year.
1985	Luis Carlos Méndez (ch. 1) arrives at El Materno as a rural in medicine (one year of mandatory social service for recent graduates in health disciplines). (ch. 2)
1985	Rosalba Bernal (ch. 3) arrives at El Materno as a rural in nursing.
1985	Germán Sandoval, physician chief of surgery.
1985	Sister Emita (Sor María Emma Muñoz, ch. 3) is hired as nurse assistant.
1986	Rosalba Bernal is hired as head nurse chief of surgery. (ch. 4)
1986	Germán Sandoval, Director of Surgery.
1987	Rosalba Bernal becomes Chief of Pharmacy. (ch. 4)
1987	Elena Fino (ch. 1) passes the admission test for the FMUN.
1988–1992	Carlos Pacheco's first term as auditor/director of El Materno. (ch. 4)
1990	Mother Teresa Vecino retires as chief of El Materno's nursing department. Head nurse Rosalba Bernal becomes the new chief. (ch. 4)
1990	Law 10. Decentralization law.
1990	Law 50. Neoliberal labor reform.
1991	WHO's Sasakawa Health Prize awarded to Edgar Rey and Héctor Martínez.
1993	Law 100. Market-based/privatization of social security, including health and pension.

1995	Santiago Currea becomes auditor/director of El Materno (ch. 4). He finished his term early 1998.
1996	New collective agreement signed with El Materno workers.
1997	$3.6 million loan to El Materno and contract with Social Security Institute (*Instituto de Seguros Sociales—ISS*).
1997	Sonia Parra, head nurse chief of surgery, is designated as responsible for administrating admissions. (ch. 4)
1998	Ariel Ruiz becomes auditor/director of El Materno for a short term. (ch. 4)
1998	Verónica and Maria's miracle. (ch. 3)
1998–2001	Carlos Pacheco's second term as auditor/director of El Materno. (ch. 4)
2000	HSJD is closed down.
2001	Manuel Mercado becomes auditor/director for a short term.
2001–2005	The Ministry of Health brought external auditing firms, primarily McGregor, to oversee the hospital finances.
2002	Law 735. Declares HSJD and El Materno as National Patrimony and Centers for Education and for the treatment of the poor.
2003	Odilio Méndez, retired pathology professor, becomes interim director of El Materno. (ch. 4)
2004	Odilio Méndez, supported by El Materno Defense Committee, becomes auditor/director of El Materno.
2005	Threats of closure by Pablo Ardila, governor of Cundinamarca Department, as the government official responsible for the Beneficencia de Cundinamarca.
2005	Leidy and Yerson, Berenice, and Carmenza deliver their babies at the hospital in the middle of the economic crisis. (ch. 5)

2005	Rosaura, secretary, Raúl, nurse assistant, Lucía, secretary, Yamile, nurse assistant, Nancy, nurse assistant, Yolanda, X-ray technician, Amparo, secretary, Jefferson, porter. (ch. 5)
2006	Lida Pinzón is the director of KMC. (ch. 2 and 5)
2006 (June)	Final agreement to "save" El Materno.
2006 (July 1)	Liquidating agent Ana Karenina Gauna Palencia is appointed by Pablo Ardila, Governor of Cundinamarca.
2006 (August 1)	Police come into the hospital. La Cruz starts operations at the hospital.
2006 (October 23)	Agreement with La Cruz overseen by the Office of the Defense Attorney.
2006 (December 26)	Head Nurse Patricia Farías signs resignation letter. (ch. 5)
2006 (December 28)	Edict announcing the end of the working obligations for the remaining workers.
2006	Gustavo, nurse assistant, Yolanda, X-ray technician, Flor, general services, Marisol, secretary, La Carpa members, Camilo, member of the Critical Medical Anthropology research group. (ch. 6)
2006	Esperanza, nurse assistant, is rehired by La Cruz (ch. 7)
2007	KCP reopens under La Cruz's administration. Esperanza, nurse assistant, is appointed to the program. (ch. 7)
2007	Alcira Muñoz, La Nacional professor, collaborates with KCP. (ch. 7)
2008	Matheo, son of Patricia Farias, passes the admission test to the FMUN. (ch. 8)
2008	Agreement with Hospital San Carlos as training sites for students of FMUN.
2008	Constitutional Court Sentence (SU-484) recognizes workers' entitlements to all their benefits but sets up cutoff dates for the contractual obligation. (ch. 6)

2008	Head Nurse Sonia Parra rehired by La Cruz as chief of surgery. (ch. 7)
2011	José Antonio and Rosa had Oscar at El Materno and enrolled in the KCP. (ch. 2)
2011	Strike of Medical School students and residents from La Universidad Nacional. (ch. 8)
2013	Nicolás passes the admission test to the School of Medicine of Universidad del Valle. (ch. 8)
2015	Yadira Borrero's research on social mobilization around health. (ch. 8)
2015	New Hospital Universitario Nacional (HUN) opens.
2016	HUV (Hospital Universitario del Valle) invokes the bankruptcy law. (ch. 8)
2016–2020	New labor conditions, including interns and residents, Elena Fino, Lida Pinzón, Luis Carlos Méndez, Adriana Ardila, Guillermo Sánchez. (ch. 8)
2019	Final eviction of workers from La Carpa. (ch. 6)

INTRODUCTION

When the Colombian government shut down the San Juan de Dios Hospital complex in 2000, it put an end to over 400 years of history of medical practice in Colombia and close to 150 years of the hospital's relationship with the country's most important public university, *Universidad Nacional de Colombia (La Nacional)*. Students from La Nacional's medical school and other health care schools were left without a university hospital, except for their training in gynecology and neonatology at El Materno, which had managed to remain open. When government officials announced in 2005 that El Materno was economically unviable and that a liquidation of the hospital assets would be the only way to pay off its accrued debts, the hospital's director, the workers, and the professors confronted this liquidation announcement and decided to remain at the hospital, fighting for its survival.

What happened? How did the country's main university hospital complex get shut down? How did government officials declare the country's most important maternal and child health care institution dispensable and threaten it with closure? The common answer in academic and public health circles is that these hospitals succumbed to the 1993 neoliberal health care reform that ordered the implementation of a market of insurance companies and providers. Many public hospitals were forced, under threat of closure, to adopt a clear market orientation. Others were closed down and reopened after a drastic for-profit administrative restructuring. Thus, the

common answer sees think tanks and Colombian government officials and legislators as successfully turning neoliberal ideology into a full-fledged, market-based health care reform that destroyed many public institutions, including El San Juan and El Materno. But "What happened?" can also be a profound ethnographic question: one that demands a multilayered answer accounting for historical trends, legal maneuvering, people's experiences, and collective efforts to defend the hospital. Thoroughly answering this question destabilizes the commonly accepted idea of neoliberal health care policy reform as a linear, uncontested history that occurs equally in all places and results in the privatization of public health. In this book, the history of "what happened" illustrates how capitalism transformed (and continues to transform) the Colombian health care system during neoliberal times, and how this transformation is full of violence, conflict, hope, and uncertainty.

Logically, transforming a health care system implies the existence of a former structure and its replacement with a new one. This happened via the implementation of multiple pro-market reforms, at different moments in time. One could say that the main transformation happened when Law 100 (the law that privatized the Colombian health care system) was signed on December 23, 1993. Law 100, however, was both the culmination of a set of political fights and the beginning of a new series of confrontations under a new framework of action. Laws evolve over time, both legally, as regulatory decrees get implemented, and socially, as the decrees transform existing conditions and social interactions around the area of regulation: in this case, health. Thus, El Materno's history during the decades before and after the reform, the core of this book, serves as a case study of the social life of neoliberal health policy—what we might call a lawfare strategy implemented by market forces.[1]

When health is the area being restructured and market-based health care reform is the technique of power that capitalist sectors use to further their for-profit interests,[2] other relevant questions emerge. What is being transformed? Health care legislation? The operations of health care institutions? Or, more fundamentally, the practice of medicine and the essence of health care? A plethora of discussions have followed, concentrated on evaluating the reform through studies of coverage, pricing, availability, quality, affordability, equity, clinical indicators, and so on. Many critical perspectives analyzing the bourgeois notions that sustain public health and political economy have played an important role in refuting claims about the reforms' success. Nonetheless, *we*[3] aim to advance a different critical perspective here,

one that emphasizes the substrate being transformed; in short, health and medical care.

In using El Materno's story to understand how health and medicine are transformed by neoliberal policies, we do not confine the analysis to how the transformation relates to profit increases in the health sector. Rather, we demonstrate how El Materno's history illustrates the sets of cultural norms and health care practices that must be established and those that had to be devalued and extinguished for the new for-profit health care structure to become hegemonic. In service of this project, we offer examples of the epistemic conflicts and contradictions that flourished as certain capitalist sectors (i.e., insurance companies) expanded into the health field in neoliberal times. Our objective is to align this ethnography not with debates around how neoliberal health policy affects public health or clinical outcomes, but rather with the conflicts that arise around transforming epistemologies of care.

Epistemologies of Care under Capitalism

By "epistemologies of care," we mean the ways in which medical care is created, practiced, taught, experienced, researched, validated, and confronted: processes that are embedded in particular historical frameworks and connect health care with affects, politics, and markets. The epistemological debates that we advance here are not those between ways of approaching and understanding reality; they deal, rather, with contestations about which reality one is studying, participating in, and creating. Boaventura de Sousa Santos clarifies that there is never a single epistemology. Instead, there are many ways of knowing that are in constant struggle, particularly in postcolonial settings.[4] Indeed, the kind of knowledge and praxis that emerges from social and political struggles in the Global South, such as those that happened at El Materno, "cannot be separated from those struggles."[5] Hence, we need to contextualize different intellectual, educational, and practice-oriented traditions within their particular historical contestations.

The main struggle faced by these epistemologies of the South is the dominant Western epistemology that credits value only to one kind of knowledge deemed universal and scientific, which emerges and is sustained through the forces of capitalism, colonialism, and patriarchy.[6] Hence, we can argue that there is a dominant epistemology of medical care that originated with Western colonialism and co-evolved with the forces of capitalism, modernity, patriarchy, and racism. Despite its dominance around the world, this

epistemology of medical care, which is frequently called biomedicine, is in constant confrontation with other epistemologies of medical care from the Global South, including the one advanced by El Materno through its centuries of history, which this book will unveil.

In order to advance our analysis of the epistemology of care, it is important to understand one of the main characteristics of contemporary capitalism in its neoliberal phase. Neoliberal or market-based health care reforms speak to the commodification of health care service delivery through the institutionalization of individual rather than social insurance, which require the co-production of life, markets, and law around neoliberal principles of health care financing, delivery, and administration. Hence, the introduction of insurance companies in Colombia as a key capitalist health sector disrupted the existing hegemony of the medical industrial complex (MIC) as prime constitutive of biomedicine during the mid-twentieth century (i.e., the pharmaceutical industry, biotech companies, and for-profit physicians and hospitals), which was maintained by the limited social pact of the welfare era characteristic of Latin American countries after World War II.[7]

During the mid-twentieth century, more health-related products became available, and their prices continued increasing through patent protection mechanisms, regulated market competition, and tendencies toward consolidating oligopolies. Key economic and political challenges started to emerge: how to make sure that governments of developing countries continued purchasing new pharmaceuticals and biotechnologies from developed nations while ensuring that they paid their foreign debt obligations? How to respond to the demands of capitalists operating in the health sector (the MIC) to maintain and increase their profit rates? How to finance this increased consumption of health-related products around the world while acknowledging people's limited purchasing capacity and governments' limited budgets?

The capitalist solution proved to be very lucrative for a sector that had previously not been able to profit from health care, the financial sector. The model of individual and private health insurance had a long history in the United States but was virtually unknown in the rest of the world. Then, the questions were: how to shift regimes of capital accumulation from former welfare state configurations with significant government investment and control to a global neoliberal doctrine characterized by the financialization of the economy? What would it take to develop a new model of "deregulated" health insurance markets around the world?[8] As with other critical moments in capitalism's history, where violence had been a standard strategy,

the imposition of neoliberal health policies has not been the exception.[9] Capitalist violence during neoliberalism has taken different forms. Even though it has been supported by dictatorships and authoritarian governments, with the associated political violence and repression, it has also included coercive shock doctrine strategies such as structural adjustment policies, or the conditioning of international loans to the implementation of neoliberal reforms in arenas including health care reform.[10] The end result of this overly simplified history of neoliberalism—that took place primarily during the 1980s and 1990s but is still ongoing—has been the expansion of insurance companies' global markets via policy reform.

In Latin America, neoliberal reform demanded the dismantling of whatever pension and health benefits of the insufficient and fragmented welfare state[11] to open the door for a market of insurers and providers. It required a new set of institutional practices and subjectivities that facilitated the circulation of money in different ways. If the main goal of the reform was the incorporation of an intermediary that administered health insurance policies, the reform had to put an end to government's direct funding of health care and transform bureaucratic mechanisms for affiliation, networks, billing, and payments.[12] Thus, this process demonstrates the development and implementation of a legal technology (health care reform) and aggressive and violent mechanisms of control that are necessary for maintaining power.[13] Control, in this case, refers to a reconfiguration of each capitalist sector's actions, transactions, and profits. Control also refers to the effective transformation of the social dynamics of health care, which include all the activities of those involved in the health service delivery sector, including patients, providers, and administrative staff. El Materno's case will illustrate how different power control mechanisms operate, more or less violently, and how they relate to students, patients, workers, and professors from the country's main public university.

Besides the profits generated directly out of medical care—whether commercialization of biotechnologies and pharmaceuticals, payments for appointments or hospitalizations, or labor exploitation of the health care workforce—it is the promise of new markets, its speculative characteristics that draws investments. Indeed, in order to expand their markets, transnational health insurance companies required countries to develop and pass market-based health care reforms[14] but, perhaps more importantly, needed the consolidation of a market mentality in these countries, meaning that life and health are acknowledged and accepted as individual risks that should be individually "insured."[15]

Investments into the future, Michael Fischer clarifies, are not only financial but also psychic, cultural, and political, and as such, require work and the construction of collective ideas as to what the future could be like. Such investments, still following Fischer, require a recalibration of life as a credible future, with anthropology being particularly well equipped to untangle what underlies those attempts to build the future.[16] Of course, capitalist investments and the social recalibrations they aspire to are contested, particularly when imposed on political projects that are trying to create alternative futures. El Materno's history will illustrate how the power play between two future-oriented investment projects is not simply a debate between public versus private/insurance-based health care systems. The historical, political, and cultural struggle is about instituting an epistemology of profits that relies on particular institutional structures[17] in which health and life are enabled as profitable insurable commodities. This process requires the displacement of an epistemology of care that profoundly believes in the public character of health care and in subaltern—and often feminized—practices of caring.

Hence, medical care here is not simply the neutral or ahistorical application of standardized biomedical interventions. Medical care, several studies have clarified, is a profoundly affective labor in which intersubjective relationships are constituted by the material and political histories of infrastructures, health care systems, patients, and, we will add, policy.[18] The affective practices, the "heart" that one pours in medical care settings,[19] speaks to the creation of communities of care that contest the colonial, scientific, capitalist, racist, and patriarchal aspects that continue to shape the epistemology of care that biomedicine represents.[20] Drawing from feminist scholarship, the affective labor of care disputes its devalued place in capitalist systems, while simultaneously emphasizing that it cannot be reduced to monetary transactions.[21]

Feminist perspectives and analyses of care help us understand how at different moments El Materno's team practiced attentive listening and acted in solidarity with women and their children even if their provision of health care services was still defined by biomedicine, patriarchy, racism, and capitalism.[22] While it is true that El Materno shared with other overcrowded public hospitals in Latin America "the lack of respect for birthing women and of sensitivity to their needs in assembly-line childbirth,"[23] with even two women in labor or postpartum sharing a stretcher,[24] there was also a deep awareness and acknowledgment that it was women themselves, and not

the medical teams, who could offer the biological and psychoemotional tools to grant the best possible care for their children.

This ethic of care, which was constantly growing and changing, was also the result of a "clinical social medicine" approach (chapter 2) in which gender, class, and race inequalities were acknowledged as fundamental in order to provide the best possible care for women and their babies.[25] Hence, negotiations about the role of clinicians and biotechnologies in the care of women and their newborns were constant. While pathologies in gynecology and neonatology continued to be understood in biomedical terms, affective and effective forms of care were seen as a process of collaboration between the institution and the women and their families. Importantly, clinicians and medical teams debated how to best support the women and their families. In a complex mix of patriarchal and antipatriarchal narratives, clinicians would even instruct fathers and other relatives to make sure that domestic responsibilities did not fall on the recovering women and, quite the opposite, that they were treated as the "household queen." Since most women treated at El Materno were poor, the best standards of care demanded not only a full understanding of their living conditions but also the design of medical protocols that incorporated life challenges both at the hospital and at home. El Materno's epistemology of care, then, was a constant struggle between reproducing and dismantling well-known patriarchal, classist, and racist legacies of colonial medicine in obstetric care.[26] And this epistemology of care, always in the making, was institutionalized and passed on to new generations of students, workers, and families, who would start experiencing, witnessing, learning, and practicing it.

El Materno's history confirms that men are frequently, although not exclusively, the ones who reproduce many forms of symbolic, linguistic, psychological, and physical violence against pregnant women in medical settings, including obstetric violence.[27] However, El Materno's history also shows that men can be exemplars of how to embrace, perform, and teach an ethics of care that challenges patriarchy in women's care, even if with significant contradictions. As Carol Gilligan made clear in her groundbreaking work, the ethics of care is not feminine but feminist, meaning a more radical movement that moves away from the binary and hierarchical gender model and goes to the root, to humanity itself. Rather, feminism should liberate democracy from the patriarchal order.[28]

It would be a stretch to conclude that El Materno's team was in the process of liberating medical care from the patriarchal order. Nonetheless, less

biomedical intervention and acting in solidarity with women and babies did mean that clinicians learned to control the urge to intervene with powerful biotechnologies to "save the women and their babies" (see chapter 2). Even the mechanical metaphors that biomedicine uses to describe and diminish women's bodies and reproductive capacities described by Emily Martin were not always assumed by El Materno's physicians and nurses to be universal or desirable. It is unclear if they thought of these metaphors as sexist and bad science,[29] but they would definitely argue that the disregard of women's bodies or their intellectual, emotional, and practical knowledge led to bad medical care. In this process, inspired by Gilligan's work, we can say that birthing and caring for newborns at El Materno was becoming more democratic than at other maternity hospitals.[30] El Materno's epistemology of medical care further contests the idea that acts of care and caring can be evaluated as either feminist or patriarchal, or totalities; that is, "fully feminist" or not.[31] Rather, in a single act, a male physician can be not only reenacting male superiority to the subordinate women that surround him (nurses who are mostly women and the pregnant woman who is subjected to the mandatory lying-down position) but also subordinating himself as he assumes a facilitator's role and elevates each woman as the most important person in the labor required to celebrate the arrival of the new life and, later, to take care of the newborn. It is in such acts and relationships that feminist and anticapitalist ethics of care can never appear as a totality but always as a creative struggle with oneself, with others, and with history.

Of course, women's solidarity and leadership were also paramount in shaping an epistemology of care that confronted existing patriarchal structures and practices at El Materno and later leading the fight to keep the hospital open. Such recognition of the role of women in shaping El Materno's history and the recognition of El Materno as an institution with the mission to care for women also resulted in an unequivocal acknowledgment of the stature of women as patients, workers, or leading medical scientists and care providers. Hence, beautiful exemplars of a liberating epistemology of medical care practiced by both men and women appear hand in hand with remnants of the colonial matrix that shape biomedical power and involve patriarchy, capitalism, and racism.

As market-based neoliberal reforms threatened and ruined the very existence of public hospitals, they also attacked specific "subaltern forms of care" that defied not only biomedicine but also its ingrained patriarchal and racist order. Hence, through El Materno's history it becomes evident that a capitalist destruction of these kinds of subaltern epistemologies of

medical care implies an attack of all the aspects that made that care subversive, including, as we will see, challenging biotechnologies as the best standards of care, imposing medical knowledge over women's knowledge of their own bodies, acknowledging the need for stable and well-paid jobs for the worker's body, or deeply caring for students' needs that bridge a feminist ethics of medical care with a feminist ethics to medical pedagogy.

In this context, medical care becomes loving forms of caring in which what matters is not only a successful medical treatment or recovery but also a deep concern about the other's well-being and a plethora of medical and nonmedical actions that ensure that patients, families, students, and workers are well cared for. Such epistemology of medical care transcends clinical and scientific parameters to propose ways of seeing, knowing, and being with one another that are closer to feminist and anticolonial proposals that this book aims to convey.

Shifts in health care policies and funding facilitate certain kinds of care while negating or ruining others. The book title *Health in Ruins* is intended as a powerful metaphor for the current situation of the hospital and its workers and for the larger state of health care in Colombia. El San Juan's abandoned and collapsing buildings were declared national patrimony because of their beautiful colonial/European architecture. Unlike other material patrimonies, however, the buildings have received scant resources for maintenance and repair. Despite the official declaration, the hospital complex's buildings are not being preserved; rather, governmental neglect aids the decay process's strength and speed. Nonetheless, as Anne Stoler argues, all ruins, including these deteriorating buildings, are active and alive.[32] Workers go daily to the hospital to await final payment of their severance, meaning a dual process of time-related deterioration that affects infrastructure and workers. As time passes, buildings, people, and their epistemologies of care are becoming memories, legacies of the past.

The book title also aims to convey the purposeful process of ruination during neoliberalism: a politics of transforming buildings and people into ruins. This process of ruination uses political neglect as a major strategy; its violence resides in inaction.[33] Such ruination becomes "incarnated" in people and buildings.[34] Besides its physical and emotional destruction, ruination has a powerful symbolic role in that it transforms the social constructions of the hospital complex and its workers. If, before, the hospital and its workers were considered the epitome of modern medicine, the shift toward market-based practices required turning their public image into an obsolete, outdated, and undesirable wreck.[35] This destruction of symbols

of particular social value opened up the possibility of colonizing new symbolic spaces, in this case around epistemologies of care. But we can never forget that ruins are always open for historical reinterpretation, even more so when ruins (buildings and people) continue to speak and produce "artifacts."[36] These specific health ruins are part of a larger political process of resignification, which depends on political proposals that pretend to speed up their destruction, convert them into museums, or recuperate them as university-based and public health care institutions.

A tension persists: the more the ruin is destroyed, the less symbolic power it has as a physical presence. And yet, the more it is destroyed, the more terrifying it looks and the more threatening its legacy can become for the interests working to consolidate a market hegemony around health care. Thus, *Health in Ruins* is intended both as a testament to capitalist acts of violence during neoliberalism (both active and passive destruction of material and immaterial elements) and as a legacy of a kind of care that can help defeat the growing influence of capitalist sectors in global health.

Struggles around the kinds of citizenry and epistemologies of care that are valued or devalued are more visible at public and maternity hospitals like El Materno.[37] What this book adds to the analysis of health and capitalism's coproduction is the interplay between the profit-driven epistemology of care advanced during neoliberal times and El Materno's, which finds creative ways to confront, contest, and survive, even if in alternative, precarious, partial, or broken forms.

This book aims to convey El Materno's epistemology of care in its rational, emotional, scientific, historical, and contestatory domains, how it is taught and learned by professors and students, how it is practiced by larger health care teams, how it is experienced and learned from patients, and how it has been transformed and ruined over time by shifts in capitalist accumulation in health care. And yet one of the book's main arguments is that as the hospital's ruination progressed, these subaltern forms of care found creative ways to continue existing, for history can never be silenced.[38] El Materno, in short, is an example of a very particular history of a subaltern epistemology of medical care that continues to exist even without infrastructure.

History and Hegemony: The Challenges to Ethnography

All ethnographies face a circular problem: how to incorporate history, given that they are in themselves historical accounts? Anthropologists are constrained by the specificities of time, region, and access that define their

fieldwork. History usually makes its way into our ethnographies through a mix of oral history, secondary sources, and a deep immersion in what is known about the people, region, and topic we are studying.

For this ethnography, we have taken the challenges of history and anthropology in the opposite direction. Our task is not to convey how history informs the data or to coalesce history and fieldwork data in a meaningful explanatory and narrative way; rather, we want to make clear that this ethnography is part of a longer historical process that neither started with the field nor finished with the ending of this book. In this perspective, the question of "What happened?" takes a new form: "What is happening?" With this new question, we aim to represent fairly the many histories and experiences occurring at the hospital in particular moments while avoiding simple contextualization (i.e., this happened within the context of health care privatization) or a simplified consideration of history as directly causal (i.e., this happened because of neoliberalism). The question "What is happening?" then corresponds to a deep ethnographic inquiry within history, which requires profound attention to the details of individual and collective action and discourse and a critical understanding of the forces that are maintaining order *while* producing change.

Seen this way, history is never entirely of the past, a total rupture, nor is it a series of successive events. Structural forces—for example, the need of capital accumulation to expand across borders and into new domains such as health—did not originally come into being alongside neoliberal reforms. In other words, the coproduction of health and capitalism, as a system of economic production and social organization around health, did not begin with neoliberalism, even though neoliberalism did drastically change that relationship. This ethnography aims to contribute to the growing body of ethnographies of neoliberalism and health through a different understanding of what neoliberalism is and how it is enacting its power.[39] Neoliberalism, from an anthropological perspective, is neither a "historical moment" that we can encapsulate in set definitions or descriptions (deregulation, free market, privatization, fiscal austerity, and so on), nor a cultural trope that defines a new era.[40] Neoliberalism is a historic and dynamic process of class reconfigurations characterized by a new global pattern of capital accumulation with profound contradictions at local levels, in moments when capitalist hegemony, rather than being consolidated, is in fact destabilized.[41]

Hence, the concrete historical "moment" of this ethnography is not neoliberalism itself, but the period in which neoliberalism is trying to become

hegemonic. This conveys both an ethnographic sense of spatiality that is no longer about enclosed communities or geographic boundaries and a sense of historical spatiality—of considering simultaneously the *where* and *when* of events. To focus on a particular locale allows us to connect ethnographic studies with the diverse development of capitalism around the world. Locale, in this case, includes both that idea of specific spatiality and the multiple influences and connections that form the locale. Thus, the locale under discussion here is both El Materno, and, as regards health and social security, Colombia more broadly. This book, then, focuses on the conflictual process of transforming epistemologies of medical care in a particular locale within a larger historical trend that illuminates what is at stake as capitalist sectors work to develop new regimes of accumulation and what the role of health is in that process.[42] This is why we have structured the book as an ethnography of hegemonies around health care epistemologies.

While the Gramscian notion of hegemony acknowledges the complex relationship between power, social praxis, and subjects, it is careful to negate any historical possibility of full conquest and, consequently, full transformation. Like Sherry Ortner, we find the Gramscian notion of hegemony "as strongly controlling but never complete or total to be the most useful."[43] Hegemony has characteristics of power and dominance, but it is never total nor absolute. Hegemonies "are never total in a historical sense, because in the flow of history, while one may talk of hegemonic formation(s) in the present, there are always also remnants of the past ('residual') hegemonies and the beginnings of future ('emergent') ones."[44]

The Gramscian concept of hegemony exceeds any exact definitions. Precisely because of its Marxist legacy, Gramsci used hegemony methodologically rather than theoretically, as a way to "explore relationships of power and the concrete ways in which these are lived."[45] Hence, with hegemony, Gramsci refuses to "privilege either ideas or material realities, but to see them as always entangled, always interacting with each other."[46] In Gramscian thinking, power relationships can take different forms in different contexts, on a continuum characterized by brute force, coercion, and domination at one pole and willing consent at the other.[47]

Such potential to understand why subaltern groups can consent to (and reproduce) those tacit and covert relations of power,[48] or advance different strategies for resistance and, eventually, subversion,[49] can explain why Gramsci was very influential to many prominent Latin American thinkers of the mid-twentieth century.[50] Within Cold War geopolitics and the many military, political, and economic aggressions of the United States in the

region, Gramsci's uses of hegemony to link historical power with human action and political consciousness were indeed very appreciated. The possibility to understand the domination of subaltern cultures and articulate academic inquiry with emancipatory projects was echoed among many Latin American scholars who were already, by Gramsci's definition, organic intellectuals. Indeed, Gramsci's translated work transited from university centers to unions and social movement struggles, and people appropriated and redefined his categories in many creative and political ways.[51]

Contemporary Latin American scholars have expanded the historical reach of hegemony as an analytical category to explain the long-lasting effects of the social configurations of the colonial matrix of power that still influence ongoing struggles for liberation in the region.[52] As capital accumulation shifted during neoliberalism and expanded to areas such as health, the colonial matrix of power in Latin America was destabilized from above. Specific technologies of market power, such as Law 100 in Colombia, stir a range of changes in the political, economic, administrative, and everyday relationships happening at health care institutions. To create its new infrastructure and maintain power, neoliberalism in health needs new mechanisms of social control, including violence and coercion, that exhaust, devalue, co-opt, or transform specific epistemologies of medical care that contest the idea that health is an insurable commodity. Without people's acceptance of this new market mentality, however, neoliberalism will have a harder time gaining hegemony.

One specific action at El Materno clarifies the fruitful possibilities of using Gramsci's fluid and methodological take on hegemony for our analysis.[53] After the market-based health care reform, El Materno directors and administrators saw that their only chance of ensuring steady incomes—of survival—was improving their systems of billing insurance companies for medical activities. Nonetheless, they were not willing to compromise their standards of care and so invented many clinical, administrative, and economic strategies that allowed them to provide comprehensive care even to patients who could not be entered formally into the system. So, how are we to analyze their willingness to engage with the billing logics of the health care market? It is clear that they were coerced into seeking profits—an action of class power enforced through legislation that changed the administrative logic of the system. But they also implemented strategies for staying true to their standards of medical ethics and medical care, which prioritized medical needs over market-based administrative requirements. How is market power exerted here? How extensive is it? What does it accomplish?

Has it changed the ways medical care is practiced? Are resistance practices overcoming or subverting market power? Are El Materno workers being co-opted by the market, or are they inventing ingenious anti-market practices and planting seeds for a future subversion of market-based medicine? Obviously, we can offer no simple answers. But hegemony invites us to think about institutional actions (i.e., improving the billing system) and individual actions (i.e., correcting the code of a procedure in the billing system to ensure payments) as part of a larger set of power dynamics in which domination is occurring and, at the same time, resistance is taking place. Only by studying the specifics of these actions within the larger historical process of class conflict's evolution over time can we learn how dominant market forces are, how hegemonic they are becoming, and, quite importantly, what strategies are being orchestrated to challenge their hegemony. Thus, we understand Gramsci's invitation as opening up the field of power relationships around capital, class conflict, and subjectivity to history, rather than close it down by way of facile contextual or deterministic conclusions.

Hospitals such as El Materno run under a specific epistemology of the public and, as *Health in Ruins* will show, an epistemology of comprehensive and humane care characteristic of the mid-twentieth century welfare state in Latin America. Under this epistemology, patients, regardless of their ability to pay, would receive all necessary care. This benefited the medical industrial complex and kept its market hegemony strong; generally, profits flew to the medical industrial complex sectors, the state fulfilled its promise of providing care, practitioners provided the best available care based on their training and according to their oaths, and patients received the medical care they needed.[54] Often, as the book will show, the care provided departed from the biomedical model or was considered merely a complement to more important natural and social modes of care for Colombian women and their babies. Thus, biomedicine, as an expression of capitalism and modernity in health, was widespread in Colombia and practiced at El Materno before neoliberalism, but it was an epistemology of medical care that was not *entirely* hegemonic.

Ethnography as a Collective and Political Project

How does one conduct an ethnography of a hospital threatened by privatization? This ethnography belongs to the Latin American tradition in which ethnographic work is assumed as always political, with many anthropologists supporting counter-hegemonic struggles and subaltern ways of think-

ing about power and reality.[55] Colombian anthropologist Myriam Jimeno, for example, argues that Latin American anthropology has a "critical vocation" that reflects the anthropologists' "dual position as both researchers and fellow citizens of our subjects of study, as a result of which we are continually torn between our duty as scientists and our role as citizens."[56] The reflexivity involved in this kind of ethnographic work questions what is "ethically important" in anthropological research, which does not reside in ethics approvals or consent forms but in the deep questioning of how the researcher's political actions are advancing counter-hegemonic struggles or enhancing oppressive power structures.[57] As Brazilian Roberto Cardoso de Oliveira argues, the ethics of anthropological work in Latin America is about acting; in other words, a politics of participation.[58]

Hence, two relevant questions emerge for anthropological exercises that presume to be political or activist oriented. First, who conducts the ethnography? And second, what kinds of actions do ethnographers take while engaging with their fellow citizens in political struggles? This particular ethnography of El Materno must be understood as a group effort. While I (César) initially approached the hospital in 2005 and started Participatory Action Research with workers, patients, and professors, many members of the Critical Medical Anthropology Research Group acted in solidarity with hospital workers, patients, and professors and conducted other research and activist activities. Along with some friends, in 2006 I created this research group, which served as a training platform for students interested in activist-oriented research around health and a collective to discuss medical anthropology. Members of this group, primarily anthropologists and health professionals, engaged in different conversations regarding biopower and health care privatization. Importantly, while biomedical care and health care systems seemed to be a new area for anthropological studies in Colombia, several of us were familiar with how Latin American social medicine (LASM) scholars had been incorporating frameworks from social sciences into the understanding of health and capitalism in novel and important ways. Importantly, many of us had been trained at El San Juan and El Materno, and some had been born at the hospital or knew of relatives or friends who had been born or had delivered their babies at El Materno. The majority of us were suffering from the neoliberal transformation of labor; we shared family or personal histories in which the institutions where we worked were undergoing different levels of privatization that threatened job security, family economies, and future pension plans. El Materno, for many, was a personal history or a history that resonated with our experiences.

We engaged in different research projects, became members of nongovernmental organizations (NGOs) and social movements, and acted in solidarity with different social justice struggles, including those related to El Materno. Indeed, as years went by, many people from the research group participated and provided data and insights as to what was going on in the relationship between health, normalization, and capitalism in Colombia.[59] But also, each of us brought in networks of friends and activists to help with El Materno's efforts to resist and survive privatization. Over the years we came to understand that we were not only co-citizens but that it was impossible to define our subjectivities as activists or scholars since we were always engaging in action and, at the same time, conducting research. In a reflective piece, we concluded that at many moments we had failed to keep adequate and extensive field notes of what was going on, but we understood that this academic failure happened because much of our energy was dedicated to support whatever specific political action was more relevant at the moment.[60] To reconstruct notes and memories, we relied on other documents such as memos, recordings of meetings, emails, and shared conversations. As such, our collective ethnographic project assumed a collective "diary" with many members' field notes.

Furthermore, some specific actions and documents were planned, discussed, edited, or presented with members of El Materno; hence, creating a further blurring between activist-researchers and members of the El Materno community. We (the research team) admired the workers' analytical expertise and extensive legal, political, and historical knowledge about what was going on, which humbled the social scientists.[61] Since 2005 the workers at El Materno have explained the hospital's legal, administrative, and economic situation to us (researchers, journalists, and other visitors). It took us (workers and researchers) years of continuous analysis to understand what was going on and how the hospital's present and uncertain future resulted in so much pain and destruction. Acknowledging coparticipation and cotheorization has also been part of how Latin American Participatory Action Research supports subaltern struggles.[62]

Many undergraduate and graduate students, workers from El Materno, colleagues, friends, relatives, and friends of friends participated, collaborated, and coproduced in one way or another, this ethnography. It is impossible to put an end date of our collaborative relationship with El Materno, but, for the formal requirements of research, we can say that the bulk of the data were collected until 2015, with occasional follow-up conversations until 2019. While going to El Materno and formal interviews did take place,

many people coordinated workshops, searched for important material in the fight to keep El Materno alive, produced a photographic registry for the legal protection of the hospital patrimony, drafted documents for public authorities or newspapers, or simply engaged in heated conversations about health care and the future of the hospitals. All these people—the majority being anthropologists and El Materno workers and professors, but also other health professionals, administrators, and artists—can be considered coauthors. This is why a politics of a collective authorship is symbolized in our use of *we* throughout the book.

In this collective endeavor, research in itself, or this book for that matter, was not the main goal but an instrument for larger political goals.[63] Thus, there are epistemic and political implications for the uses of *we* in anthropology—not necessarily as a nonspecific notion of collective subjectivity but as a political project with collective belonging, representation, and action. Collective subjectivities are a common way to represent efforts in Latin America to combine social activists, intellectuals, and political party leaders. By assuming collective subjectivities, we do not want to convey the incorrect idea that attention to individual experiences and biographic accounts was unimportant in this ethnography; in contrast, it was paramount. However, individual biography was important for connecting particular individual experiences with larger historical processes in a critical phenomenological sense, whether in order to identify the larger process's specific implications for a particular subject or the ways in which that particular subject's history and experience influenced the larger historical process.

The most frequent action-research activity at El Materno did not differ substantially in technique from what is known as participant observation. However, the fieldwork entailed being at the hospital *with* the workers and professors; this resulted in a politics of being with them, a deeply emotional process of exerting solidarity that Myriam Jimeno calls "emotional communities."[64] Often, the research team's visits were seen as extremely important—not only because, as the years accumulated, workers and professors felt isolated and unacknowledged but also because ideas about future actions often emerged from them. We were involved as confidants and recipients of harmful gossip about hospital colleagues and forced to take moral stances around those claims. We also felt compelled to intercede and explain the perspective or situation of different groups inside the hospital in tense moments, and we intentionally reoriented political efforts toward larger goals, such as keeping the hospital afloat or securing a fair termination of labor contracts. Frequently, we felt defeated and felt that

our efforts, whether academic articles, legal documents, art activities, solidarity visits and conversations, or media denunciations, had little effect to transform the course of history. Thus, most activities, such as a workshop, a series of lectures about the hospital, the elaboration of a legal document, or the coordination of a guided visit, were not intended as fieldwork activities, even though they could later be converted into field notes through the reconstruction of the collective diary.

Understanding power and taking sides means acknowledging one's political positionality. Of course, issues of reflexivity and situated knowledge, discussed extensively in anthropological research,[65] are helpful for advancing a proposal for ethnography as a form of collective political action. An activist-researcher positionality in anthropology—rather than being harmed by a lack of the necessary scientific neutrality that is often advocated to generate rigorous scientific knowledge,[66] can produce deeper comprehensions of a specific social dynamic given that it invites researchers, research teams, and social groups to find connections between everyday life and violent coercion or willing consent. More importantly, by acting against dominant forces, we can see more clearly how power operates, what forces and strategies are being implemented by dominant groups and what actions accomplish better results and facilitate subversion, both in the short term and in later and better times.

We hope that this book itself offers a counterhegemonic force to neoliberalism by showing both its devastating effects and the many opportunities that the world has for overcoming biocapital, that is, the coproduction of health care and capitalism.[67]

Book Overview

In chapter 1, The National University Escuela, current professors of medicine and one alumna tell the story of what it was like to pass the admission test for the School of Medicine at the National University in Colombia in the 1960s and 1970s. Chapter 1 describes the political, economic, and intellectual challenges of the students during their preclinical and clinical years, during which they received practical training as medical students, interns, and residents at the most prominent public and university hospital in the country.[68]

Chapter 2, Clinical Social Medicine, paints a vivid picture of the imbricated relationship of El Materno and the rapidly growing city of Bogotá during the mid-twentieth century. In particular, we learn about "simple

alternative solution[s] to complex medical problems," strategies that professors of pediatrics and neonatology created to confront the medical challenges poor pregnant women and babies brought to a chronically underfunded hospital.

Chapter 3, Religion and Caring in a Medical Setting, emphasizes the importance of the religious presence at the hospital and El Materno's fundamental politics of care. Patients and workers came to see El Materno as their second home; devotion to work duties, patients, and colleagues further blurred the boundaries between households and hospitals. A health miracle related to a virgin apparition connects care, healing, and faith.

Chapter 4, Hospital Budgets before and after Neoliberalism, deals with the hospital's administration through the narratives of several hospital directors and section chiefs. This chapter unveils the turning point in the hospital's economic viability with the full implementation of neoliberal reforms, when state funding was completely cut off and the hospital was forced to compete for resources within the new for-profit and insurance-based system. The chapter ends with the government declaring the hospital economically unviable and threatening to close it.

In chapter 5, Violence and Resistance, we read about how workers became "burned out" from the emotional toll of a lack of patients and close to eight months of unpaid salaries. The chapter describes what it was like for El Materno workers to experience a "liquidation process" and then wait years for their severance packages. Then, the chapter turns to workers' efforts to keep the hospital afloat, satisfy their patients' rights to health, and respond to continuous threats of closure and liquidation. It details the many strategies workers implemented over the course of many years to keep fighting for their labor rights and preserving the hospital's material and immaterial patrimony.

In chapter 6, Remaining amid Destruction, workers who were rehired by a new administration and professors of the National University narrate what it was like to work in the same building but under different management. They had new, temporary contracts without benefits and with reduced pay, but at least workers had salaries and were able to continue working at "their" hospital. Professors voiced their dissatisfaction with the way the hospital was run and with clinical services that had been reduced to what was successfully billable. Nonetheless, they remained determined and committed to staying and fighting for their roles in the university/hospital system.

Chapter 7, Learning and Practicing Medicine in a For-Profit System, integrates the voices of recent graduates from the National University, who

explain what it is like to graduate from the School of Medicine without having received training in its legendary hospitals. Their voices and those of the professors who oversee medical students, interns, and residents illustrate many of the current problems of medical education and medical care in Colombia.

In the Final Remarks, Medicine as Political Imagination, we link the hospital's history with other processes of ruination of public health care and the protest they are generating around the world. This section helps us realize that other stories like El Materno's are happening in other places, as the neoliberal "health insurance logic" garners expanding influence around the world.

NOTES

Introduction

1. See Appadurai (1995) for the formulation of studying "the social life of things." For neoliberal legislation in postcolonial settings and the concept of lawfare, see, in particular, Comaroff and Comaroff (2006). For discussion of the law as a technology of power, see Coutin and Yngvesson (2008).

2. This initially happened in Latin America and was later exported to other geographic areas in both the Global North and South. Significant restructuring occurred more around pension funds than health (Stocker, Waitzkin, and Iriart 1999; Iriart, Merhy, and Waitzkin 2001). The Colombian case is particularly interesting because it was the country where the most comprehensive market-based health care reform took place. For original work by academic neoliberals on this subject, see Londoño and Frenk (1997). For its original expression in international financial institutions' documents, see The World Bank (1993).

3. Why this book uses "we" to signal collective authorship will be explained shortly.

4. (Santos 2018).

5. (Santos 2018, 2).

6. Santos, as other postcolonial and decolonial scholars, draws from the understanding of a colonial matrix of power, as originally discussed by Quijano (2000).

7. (C. Giraldo 2007).

8. We use quotation marks here to indicate that several scholars disagree with the idea advanced by some government officers, international institutions, and academics that neoliberalism is a completely deregulated "free market" resulting from the total dismantling of the state. In contrast, neoliberalism advances new roles of the state and of state actors in the reconfiguration of a global class (Jasso-Aguilar and Waitzkin 2007; Robinson 2007). In health, these thinkers argue against the idea that the market

regulates itself through competition and that the government plays a crucial role in regulating the market through specific legislation, even including incentives, and finer mechanisms of regulation such as accounting (J. Mulligan 2016).

9. Health is but one aspect of neoliberal reforms, privatization, deregulation, and financialization that happened in virtually all sectors of the economy (Harvey 2007; Klein 2007).

10. (Harvey 2007; Kim et al. 2000; Klein 2007).

11. Such fragmented welfare systems were common in other Latin American countries as well (C. Giraldo 2007; Hernández Alvarez 2004). They were characterized by three sectors: a public sector, a social insurance sector for private and public employees, and a private sector. These systems frequently suffered from inequality and a lack of articulation. With the election of progressive governments and constitutional reforms in the 1980s and 1990s, several countries made advances in unifying their health care infrastructures and strengthening their public orientations. Colombia stands in this history as an opposite example given that it moved toward full privatization.

12. Mulligan's ethnography in Puerto Rico offers important insights into the financial and administrative logics of market-based health care reform (Mulligan 2014, 2016).

13. For a historical analysis of the competing intercapitalist sectors in health and the alliance between the medical industrial complex and financial sectors during neoliberalism, see Iriart and Merhy (2017). See Waitzkin and Working Group for Health Beyond Capitalism (2018), Rosenthal (2017), and Bugbee (2019) for a description and analysis of the competing interests of several capitalist players in a U.S. context.

14. The transnational insurance sector that dealt with health insurance and pension funds began to face problems of overaccumulation; that is, insurance companies had been such successful capitalists that they saturated all their markets and could not inject their profits back into the market. In other words, there was a halt in the necessary circulation cycle of capital, which threatens with stagnation of the economy, or worse, recession. Thus, insurance companies followed what David Harvey called "accumulation by dispossession" (2007) seeking market expansion to areas, like health care, that were not previously within their reach. See Stocker, Waitzkin, and Iriart (1999); Iriart, Merhy, and Waitzkin (2001).

15. Initially, health insurance companies threatened the profits of the medical industrial complex (Iriart, Franco, and Merhy 2011). Currently, the medical industrial financial complex (MIFC) represents an alliance of capitalist sectors in health in which profits are ensured for all sectors as medical care bills and insurance become more expensive (Iriart and Merhy 2017).

16. (Fischer 2009).

17. Here, we follow Sunder Rajan when he states that the ways in which our very ability to comprehend "life" and "economy" in their modernist guises are shaped by particular epistemologies that are simultaneously enabled by, and in turn enable, particular forms of institutional structures (Sunder Rajan 2006, 13–14).

18. (Cooper and Waldby 2014; Street 2012, 2014).

19. (Wendland 2010).

20. (McKay 2018, chap. 2).

21. See Fraser (2016) for a feminist Marxist approach to social reproduction. See Smith-Morris (2018), Strong (2020), and Arango et al. (2018) for several discussions on care and caring, including feminist perspectives.

22. (Martin 2001).

23. (Shepard 2006, ix).

24. Also seen in other Global South settings. See Strong (2020) for her ethnography at a maternity ward in Tanzania and the powerful 2017 documentary *Motherland*, based on the Philippines. Nonetheless, "Global South" should not be homogenized. It is clear that regarding child and maternal health, the conditions in hospitals and even the conditions of poverty in which women and families live vary enormously among regions and within regions and countries.

25. The racial domain appears as "autonomous" or "innate" thinking that connects medical care and the human body with nature. This knowledge and respect for "mother nature" is rooted in indigenous cosmogonies. See chapter 2.

26. In a way similar to indigenous feminist proposals in Latin America that speak about the messiness and intersectionality of their struggle and stand in contrast to the hegemonic liberal feminist tradition from the Global North (Duarte 2012).

27. (Hernández and Upton 2018; Martin 2001; Strong 2020; Vallana Sala 2019). Strong offers examples of the complex maneuvering between abuse and "fierce care" in Tanzania, whereby nurses and doctors yelling at and hitting women in labor can be expected as caring practices given that they can avoid complications or even save the baby and mother's lives. Under a reproductive justice framework, however, these practices are always condoned in light of the structural elements that should always stand as unacceptable.

28. (Gilligan 2000).

29. (Martin 2001, p. xxii). Rather, they acknowledged that each birth and each woman's and child's body is unique and wonderfully powerful, hence is each delivery, or celebration of a new life as they called it.

30. As argued by midwifery proposals that demedicalize the birthing process (Davis-Floyd et al. 2009).

31. Arguably, a fully feminist practice within a larger patriarchal, racist, and capitalist global and national order would be impossible to realize.

32. Research in sociocultural anthropology rebuffs the idea of ruins as "archaeological," reminding us that remnants of the past have important contemporary meanings, which themselves affect our sense of the connections between the past and the present. Colonial histories and histories of violence experience a dual historical process of material and human interaction. Ruins speak to those histories as, over generations, people tell what happened. Ruins, rubble, debris, and so on, serve as powerful historical reminders and, as such, become material history that is itself re-created in contemporary symbols, political struggles, and interpretations. See Gordillo (2014); Stoler (2013).

33. Anne Stoler emphasizes that "ruin" is both a noun and a verb, "the claim about the state of a thing and a process affecting it" (2013, 11). She complicates ruin as a conceptual element for anthropological inquiry by linking things to their imperial history. "Imperial projects," she continues, "are themselves processes of ongoing ruination, processes that 'bring ruin upon,' exerting material and social force in the present. By

definition, *ruination* is an ambiguous term, being an act of ruining, a condition of being ruined, and a cause of it. Ruination is an *act* perpetrated, a *condition* to which one is subject, and a cause of loss."

34. See Povinelli (2011) for the concept of carnality and the role of time in late capitalist destruction.

35. What is important here is the relationship between symbol and value. Value can take many forms; anthropologists can detect these many forms and show how they overlap. Graeber (2016) suggests that value in anthropology can adopt different symbolic, material, and economic forms, which usually coalesce. In his research about an ecotourism project in Q'eqchi'-speaking communities in the Guatemalan forests, Kockelman (2016) elegantly shows how use value (function), exchange value (price), semantic value (meaning), and deontic value (morality) constantly influence each other and how specific approaches give specific values meaning at the expense of other possible interpretations. Value can travel from one domain to another (e.g., from a commercial value to a semantic value), but Kockelman demonstrates that not everything contained within a given value can be translated into the other domain. Some of this value incommensurability will be relevant in the analysis of epistemologies of care at El Materno, when we show that not all health care can be translated into economic forms.

36. Artifacts in this case can take many forms: for example, legal documents. See Góngora et al. (2013) for a discussion of legal documents as artifacts in El San Juan. The idea of thinking of documents as artifacts open to ethnographic inquiry as examples of social practices and actors' actions comes from the work of Riles (2006).

37. Even regarding race as Bridges (2011) discusses for the Women's Health Clinic at Alpha Hospital in New York. See also Strong (2020).

38. (Benjamin 2013).

39. For some of the most relevant ethnographies from medical anthropology, see Adams (2016); Bridges (2011); Cooper (2008); Cooper and Waldby (2014); Dumit (2012); Han (2012); Keshavjee (2014); Knight (2015); Livingston (2012); McKay (2018); Mulligan (2014); Peterson (2014); Povinelli (2011); Smith-Nonini (2010); Street (2014); Sunder Rajan (2006, 2017); Wendland (2010).

40. There is, in other words, no "neoliberal culture" or "culture of neoliberalism."

41. We position ourselves here against a reading of capital as supreme and victorious in the wake of socialism's collapse in Europe. Instead, we join critical scholars who read the defeat of socialist European states and the rise of neoliberalism as a new capitalist phase that brings more social contradictions and conflicts.

42. Waitzkin and other scholars insist on the need to decommodify health care (Waitzkin and Working Group for Health Beyond Capitalism 2018). With the advent of market-based health care reform in Colombia, debates abound around the decommodification of health and the need to advance a concept of health in other terms. For debates in Colombia see, among many others, Franco Agudelo (2003); M. Hernández (2003); Useche (2007).

43. (Ortner 2006, 7). See also Butler, Laclau, and Žižek (2000); Crehan (2002).

44. Here, Ortner draws on Raymond Williams' elaboration of Gramscian notions in order to connect Marxism with literary theory (Williams 2009). Crehan (2002)

adequately signals the limitations of Williams' proposal for anthropologists. Nonetheless, Williams' explanations of hegemonic configurations in history are helpful in that they help us understand the incompleteness of hegemony as emphasized by Gramsci. Hegemony is also a useful lens through which to consider the conflicts between colonial epistemologies and epistemologies of the south.

45. (Crehan 2002, 99).

46. [Hegemony] rejects any simple base-superstructure hierarchy (Crehan 2002, 200).

47. (Crehan 2002, 101). Discussing the role of the intellectuals as subalterns to the world of production, for example, Gramsci speaks of the social hegemony achieved through "spontaneous consent" and the state domination or coercive power achieved through "legal" channels (Gramsci and Hoare 1985, 12–13). As part of his view on political praxis, Gramsci notes that critical consciousness (i.e., critical understanding of self) requires the worker to be aware of the hegemonic force that has influenced his moral and political passivity. Then, the first step for a revolutionary praxis is "working out at a higher level of one's own conception of reality," a progressive self-consciousness in which "theory and practice will finally be one" (Gramsci and Hoare 1985, 333). While Crehan speaks to the dominant position of those in power, Guha (1998) reiterates that regarding hegemony full dominance is never accomplished.

48. (Butler 2000, 14).

49. (Butler 2000, 12).

50. Including the work of Paulo Freire, Liberation Theology intellectuals, and Orlando Fals Borda (Rincón Diaz 2015; Santofimio-Ortiz 2018; Vivero-Arriagada 2014).

51. (Santofimio-Ortiz 2018).

52. Following the original formulation of Coloniality of Power by Quijano (2000). See also Grosfoguel (2011). For the original critique about the intertwining of race and gender, see Lugones (2008). For colonial configurations around race, gender, and labor see Moraña, Dussel, and Jáuregui (2008, 11).

53. (Crehan 2002). Sunder Rajan also finds the Gramscian notion of hegemony useful for understanding how the pharmaceutical industry is dominating the political field of global health (Sunder Rajan 2017).

54. The system was far from perfect; see, for example, Hernández and Obregón (2002). In later chapters, we will explore the former health care system's problems through the lens of El Materno. For now, we present it as, generally, functional in order to advance our discussion of hegemony. For a general overview of the welfare state and its transformation by neoliberalism, see Giraldo (2007).

55. (Ramos 2008). See also the World Anthropology Network (WAN). See also DaMatta (1994); Escobar (2000); Victoria et al. (2004).

56. (Jimeno 2005; 2006, 72).

57. (Bourgois 1990; Victoria et al. 2004).

58. See also Hale (2006) and our own analysis of how we conducted this ethnography (Abadía-Barrero et al., "Etnografía como acción política," 2018).

59. As is the title of our edited volume, *Salud, Normalización y Capitalismo en Colombia* (Abadía-Barrero et al. 2013).

60. (Abadía-Barrero et al., "Etnografía como acción política," 2018).

61. This is evident in, for example, a collaborative and coauthored ethnography with El San Juan workers, in which the expertise of the workers is emphasized by their description as "native historians" (Góngora et al. 2013).

62. See Rappaport's work on the legacy of Orlando Fals Borda, which both clarifies and complicates the definition and praxis of PAR (Rappaport 2008, 2018, 2020). Gramscian legacy on the thinking-feeling epistemology that Fals Borda advanced is evident in Gramsci's argument that the intellectual's error "consists in believing that one can know without understanding and even more without feeling and being impassioned . . . [about] the elementary passions of the people, understanding them and therefore explaining and justifying them in the particular historical situation and connecting them dialectically to the laws of history and to a superior conception of the world, scientifically and coherently elaborated—i.e. knowledge" (Gramsci and Hoare 1985, 418). See also Vasco Uribe (2007).

63. (Ramos 2008).

64. See Jimeno, Varela Corredor, and Castillo Ardila (2015) and Macleod and de Marinis (2017) for an edited volume that expands the concept of emotional communities to other Latin American contexts. The volume expands and complicates Jimeno's original proposal.

65. In addition to Haraway's original article (1988), see also Lamphere, Ragoné, and Zavella (1997). From a Latin American perspective, see the classic work by acclaimed anthropologist Rosana Guber (2001), and the edited volume *Trabajo de Campo En América Latina: Experiencias Antropológicas Regionales En Etnografía. Tomo 2* [Fieldwork in Latin America. Regional anthropological experiences in ethnography, vol. 2] (2019).

66. Charles Hale offers important critiques of this idea (2006). He also explains the high stakes of activist-oriented anthropology, which must be accountable to the differing standards and demands of the subject and the academic communities.

67. In Sunder Rajan's original formulation (2006), *biocapital* refers to the historical coproduction of life sciences and capitalism. Here, we use it to think about the coproduction of health care and capitalism, in particular as it relates to the MIFC.

68. Throughout the book, short quotes and long passages come from conversations or interviews. The speaker is identified within the context of the paragraph.

1. The National University Escuela

1. This understanding is, of course, inspired by Rudolph Virchow's famous dictum: "Medicine is a social science and politics is nothing else but medicine on a large scale." Virchow, the father of social medicine, and all the scholars, clinicians, and activists who followed him, emphasized not only the political domain of medicine but also the fact that health is the result of politics. For the Latin American social medicine tradition see, among other reviews, Waitzkin et al. (2001). See also the association's main web page ALAMES (www.alames.org) and major journal, *Social Medicine/Medicina Social*. Our discussion here, however, takes a different approach. We want to stress how medicine