Anthropology of Work Review

# Workers' Decompensation: Engaged Research with Injured Im/migrant Workers

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## Introduction

This special issue brings together ethnographic perspectives on the intersections between structural violence and vulnerabilities, workplace inequalities, and occupational injuries among im/migrant workers in North America.[1] It responds to calls for increased ethnographic attention to the relationships between im/migration and health (Castañeda 2010), as well as attending to the troubling gaps in health-care provision, accessibility, and quality (Castañeda and Mulligan 2017; Horton et al. 2014).

The daily lives of undocumented workers are characterized by many layered challenges and uncertainties (Kline 2017; Saxton 2013). Their im/migrant, citizenship, race-ethnic, gender, and class statuses render them flexible, disposable, and cheap (Cartwright 2011; Holmes 2013; Otero and Preibisch 2015; Smith-Nonini 2011). Even before the 2018 presidential election of Donald Trump, with the expansion of free trade zones and the movement of U.S. industries abroad, some Americans blamed immigrants for their personal and societal problems (Chávez 2008, 2012; Zimmerman 2011). Numerous anti-immigrant policies have been implemented over the last 30 years, including restrictions on legal permanent residents' access to safety-net programs, redoubled surveillance of immigrants, and increased funding for a hyper-militarized and weaponized Immigration and Customs Enforcement (ICE) and Border Patrol (Chávez 2008, 2012; Coleman and Stuesse 2014; Zimmerman 2011). In the current moment, Trump's explicit anti-immigrant rhetoric and executive orders, and his emboldening of ICE and Border Patrol are heightening widespread anxiety and fear. Recent raids at a Central Valley California citrus-packing house forced ninety workers to quit their jobs or skip work in anticipation of ICE's arrival (Klein 2018). Others are going into hiding or self-deporting to avoid putting their families through the trauma and legal expense of an ICE encounter (Healy 2017).

A number of cuts and rollbacks to labor, health, and environmental agencies and protective laws also predate Trump, including the systematic gutting of the Environmental Protection Agency, the Department of Labor, and the Occupational Safety and Health Administration; welfare reforms; and exponential increases to the defense budget. State-level efforts have also defunded public education, health care, and other social services. Meanwhile, the Trump administration demonstrates a highly antagonistic attitude toward regulations of all kinds. Corporate leaders are now in charge of high-level federal positions, and a cavalcade of executive orders are obliterating, halting, and reversing decades of incremental progress to protect workers, public health, and the environment (Levenstein and Siqueiros 2017). This, combined with attacks on immigrant communities, is having severe consequences for im/migrant workers and their extended family networks and communities, both nationally and transnationally (Unterberger this issue; Otero and Preibisch 2010).

As critical scholars rooted in praxis, the contributors to this special issue carry out engaged research for health and justice, taking an explicitly political stance. This entails not merely documenting patterns of injury or analyzing injurious cultures, but sharing insights about the potentials of synergistic activist ethnographic work and concrete suggestions for improving health and welfare outcomes for injured im/migrant workers, their families, and binational communities. As Charles Hale notes, activist anthropology is "a method through which we affirm a political alignment with an organized group of people in struggle and allow dialogue with them to shape each phase of the [research] process" (Hale 2006, 97). Our insights are based on our work with im/migrant worker communities employed in North America by industries dominated by im/migrant labor, including farm work, food packing and processing, construction, landscaping, and factory work. One of the authors (Castillo) also did research with health-care providers and workers' compensation attorneys (Figure 1).

The articles in this issue contemplate the following questions: What is life like for injured im/migrant workers and their families? What are the historical

  

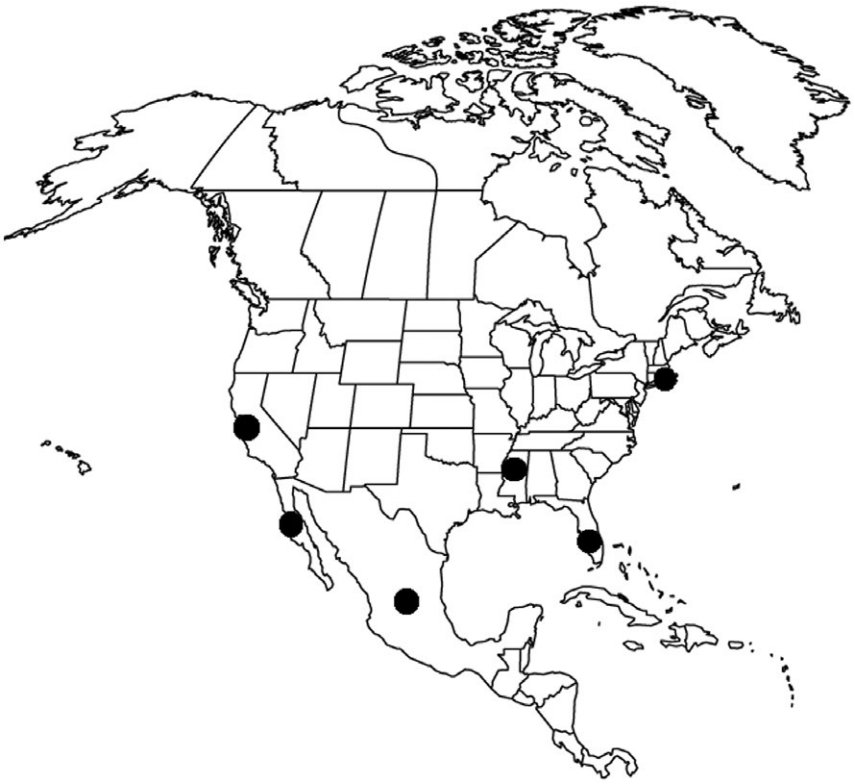

**Figure 1.** A map of the field-sites of the authors: California's Central Coast and Baja California Norte, México (Saxton), Central Mississippi (Steusse), Central Florida and Guanajuato, Mexico (Unterberger), and Rhode Island (Castillo).

origins, contemporary state, and limits of the workers' compensation system? How does workers' comp intersect with or contradict other health-care infrastructures, safety nets, and coping mechanisms? How do injuries interact synergistically in the bodies and communities of im/migrant workers? How do injured workers' vulnerabilities layer and confound one another? How do occupational injuries and illnesses affect transnational community networks, as well as the life courses and migrant trajectories of future generations?

To begin, we assess the origins of the workers' compensation system as a product of U.S. industrial history, examine its inconsistencies and inadequacies, and consider the deadly and disabling consequences of neoliberal approaches to occupational risks and health. We develop the concept of *decompensation* to describe the multilayered impacts that federal and state austerity measures, workplace hazards, and anti-immigrant policies are having on the health and welfare of im/migrant workers. We explore the limits of some approaches to occupational and immigrant health coming from public health and biomedicine, and compare them with the more holistic frameworks anthropologists have used to understand and intervene in these issues.

The ethnographic case studies by Carla Castillo, Angela Stuesse, and Alayne Unterberger, and a book review of Sarah Horton's *They Leave Their Kidneys in the Fields: Illness, Injury, and Illegality among U.S. Farmworkers* (2016) by Dvera Saxton and her students, offer comparative insights into the complexities and challenges facing work-injured im/migrant workers throughout North America. A commentary by National Institutions of Occupational Safety and Health (NIOSH) applied researcher Michael Flynn assesses this issue from an interdisciplinary and macro-policy level perspective. By "studying up" (Nader 1972) the workers' compensation insurance, legal, and health-care systems, we explore how different safety-net and health-care systems and policies intersect and sometimes counteract one another, causing an injury to one to become an injury to all. We privilege the embodied experiences and analyses of im/migrant workers, taking what Richard Wright calls the "frog perspective" of looking upward from below (Wright 1957, 6), and we challenge the assumptions that guide current workers' compensation legal and biomedical practice. This work and accompanying applications and activism are urgent as we enter an era of heightened precarity for im/migrant workers.

## The Creation of Workers' Compensation

Every year over 3,000,000 workers are seriously injured, and 4,500 people lose their lives on the job (Berkowitz 2016). Only a small fraction

  

of these receive any workers' compensation at all. Several studies place this figure at below 40 percent (Michaels 2015, 6, 7; Shannon and Lowe 2002; Spieler and Burton 2012), and one study documented that fewer than 8 percent of seriously injured workers had accessed workers' comp (Bernhardt et al. 2009). In the United States, work-related injuries are governed by a complex array of laws, insurance companies and their vetted workers' comp providers, evaluation metrics, treatment protocols, and compensation schedules. All of these vary from state-to-state, company-to-company, and injury-to-injury.

Over the last two decades, state legislatures have passed a bevy of reforms to workers' compensation that have made it increasingly difficult for injured workers to access the services they need, shifting the cost burdens of workplace injuries from employers and insurance carriers to workers and their families, nonprofits, and taxpayers, who fund an ever-shrinking and more legally constrained social safety net. For undocumented im/migrant workers in particular, the challenges to accessing basic medical care and disability benefits through workers' comp can be practically insurmountable. They work in some of the most dangerous and underpaid occupations. Their labors and bodies subsidize our welfare and the economy. How did we get to this point?

By the start of the twentieth century, the United States had become a largely industrialized economy, and workplace injuries in manufacturing had become commonplace. Both business and labor interests grew increasingly alarmed about industrial accidents. Liability lawsuits filed by workers' and advocates became overly costly and cumbersome. Companies started hiring doctors to conduct pre-employment physicals on workers and treat their injuries in-house (Starr 1982, 200, 201, 203). Industrial physicians also redesigned plant layouts and operations, attempting to prevent workplace injuries, but also enabling more stringent personnel management and surveillance and prioritizing production efficiency (Howard 2002). These strategies aimed to placate workers via corporate paternalism, and medical care "functioned as an element in this strategy of control" (Starr 1982, 202). Such practices also reduced company expenses by allowing direct control over diagnoses and duration of treatment (c.f. Castillo this issue; Stuesse this issue). This established a system that endures today; one in which the degree of one's work-related illness, injury, or disability remains "habitually understated" by companies, insurance, and medical providers (Howard 2002).

Prior to the passage of state-based workers' compensation legislation in the early 1900s, the courts decided whether or not employers bore responsibility for work-related injuries or deaths. Employers easily and swiftly contested their liability, leaving tremendous burdens on workers' families and communities (Fishback 2008; Howard 2002; Jain 2006, 18). Workers had to prove the employer's absolute negligence in order to have any chance with their cases, often requiring the worker hire an investigator (Jain 2006, 18). The injured or their families routinely faced pressures to settle out of court, receiving far less than the cost of care or a lifetime's worth of lost wages.

By the start of the twentieth century, a moral discourse on industrial workplace injury began to take shape, as evident in President Theodore Roosevelt's 1907 commentary, "As the work is done for the employer, and therefore ultimately for the public, it is a bitter injustice that it should be the wage-worker himself and his wife and children who bear the whole penalty" (Grabell and Berkes 2015). Books like Upton Sinclair's *The Jungle* (1906), which described dangerous working conditions in Chicago's meatpacking industry, and incidents like the 1911 Triangle Shirtwaist Factory fire that killed 150 workers, further raised consciousness about the plights faced by im/migrant workers and the need to address occupational health and safety hazards.

In 1911, Wisconsin became the first state to enact an enduring workers' compensation law, and within a decade other states had followed suit (Rousmaniere 2012). This compromise between business and labor became known as the "grand bargain." Employers were required to purchase insurance to protect workers injured or sickened on the job, and injured/sick employees gained access to medical care, wage replacement for temporary disability, and indemnity payments in the case of permanent disability. In exchange, injured workers no longer had to prove negligence to receive benefits, but they could no longer sue their employers. Even with these policy shifts that improved workers' odds of gaining compensation for occupational injuries, workers' comp claims were rarely successful because the rates of compensation were so inconsistent and sometimes took a long time to be paid out to the injured and their families (Howard 2002). Not all workers across industries benefited from these changes. For example, the 1935 Wagner Act, which gave workers the right to organize, explicitly excluded farmworkers (Berkey 2017). This "agricultural exceptionalism" justified lower pay, and fewer benefits, rights, and protections for farm laborers as farmers and landowners argued that the challenges of growing and harvesting food made the industry more vulnerable to economic hardship (Berkey 2017; Gray 2013; Hahamovitch 1997; Rodman et al. 2016; Rothenberg 1998; Wiggins 2009). Several states continue excluding farmworkers and/or undocumented workers from workers' compensation and disability eligibility (Farmworker Justice 2017), regardless of

  

paying into the state and federal safety-net systems with each paycheck (Horton 2016a). Temporary gains made by the United Farmworkers Movement in the 1960s and 1970s to grant farmworkers more workplace protections and legal rights (Garcia 2012; Jain 2006) have not been uniformly sustained over time. The state-based system also makes it extremely difficult for workers who migrate to receive continuity of care (Farmworker Justice 2017; Saxton 2013).

Workers' comp never became a federally managed program, in part because employers, insurance companies, and organizations like the American Medical Association fought hard against what they characterized as "socialized medicine" (Howard 2002; Starr 1982). Instead, each state legislature determines the contours of workers' comp, including: what body shall oversee its administration, the determination of an injury as work-related, the appropriate medical attention, the amount and duration of compensation, and the monetary value of an eye, finger, arm, or foot. This has resulted in a patchwork landscape of care and compensation for injured workers across the country (Grabell and Berkes 2015).

**Workers' Decompensation**

By the mid-twentieth century, injured industrial workers received considerable attention from both capital and the state. A "risk management" industry emerged to mitigate losses to corporate profits, diverting hazards, and costs onto employees and consumers (Beck 1996; Rousmaniere 2012; Smith-Nonini 2011). Still, despite growing awareness, it wasn't until 1970 that Congress passed the Occupational Safety and Health Act (OSHA) to regulate workplace hazards nationwide. One section of this law commissioned the first national assessment of workers' compensation across the 50 states. The report found the state laws grossly "inadequate and inequitable" (Burton 2003; Grabell and Berkes 2015; NCSWCL 1972; US DOL 2016, 2). Among the commission's dozens of recommendations were coverage for all employees; a worker's right to choose their doctor; wage replacement rates of at least two-thirds of the state's average wage; and compensation without time limits for as long as the disability persists (Grabell and Berkes 2015). The commission urged Congress to mandate 19 of its recommendations, but no federal regulations resulted. While some states acted voluntarily, by 2015, fully 34 states hadn't met even half of the prescribed standards (Grabell and Berkes 2015; US Department of Labor 2016).

Without a federal mandate, states have been free to roll back these minimum standards at whim. Since 2003, 33 states have enacted laws to reduce benefits or make it more difficult for certain workers to qualify (Boden and Ruser 2003; Guo and Burton 2012; Qiu and Grabell 2015; Spieler and Burton 2012). These laws have been passed amid anxieties about over-reliance on and fraudulent uses of government assistance programs and heavy lobbying by an insurance industry that claims costs are out of control all the while reaping hefty profits—an 18 percent return in 2013.[2] Meanwhile, at just $2 per $100 in workers' wages, employers are paying less for workers' comp insurance than at any time in the last quarter century (Grabell and Berkes 2015).

Little attention has been paid to recent state cutbacks in workers' comp, in part because the federal agency that used to keep track of compliance with the federally recommended standards, the U.S. Department of Labor, stopped doing so following 2004 budget cuts (Grabell and Berkes 2015). One study found a correlation between these legislative rollbacks and pressure to continue working when injured or sick (Boden and Ruser 2003), and ProPublica/NPR's exhaustive review of recent legislation across the 50 states found alarming transformations of key aspects of workers' comp provisions (Grabell and Berkes 2015; ProPublica 2015). These include granting more power to insurance companies to make decisions regarding medical treatment, capping treatment durations and provider payment schedules, and instituting outside auditors who, based on cursory reviews of medical records, are empowered to override the recommendations of injured workers' doctors (Grabell 2015a, 2015b, 2015c, 2015d, 2015e; Grabell and Berkes 2015).

In some states, cutbacks have been so catastrophic that they "virtually guarantee injured workers will plummet into poverty" (Grabell and Berkes 2015). For low-wage workers without access to employer-provided health insurance or the public option, the disparities of workers' comp and the threats of continued policy rollbacks are felt acutely. A 2015 OSHA report suggests that such high levels of subsidy of workers' compensation by other parts of America's social safety net may effectively reduce employers' financial incentives to prevent workplace accidents and illnesses in the first place (Michaels 2015, 11).[3] Employers and labor contractors may not protect workers because current financial penalties and legal enforcements are weak (Woolford et al. 2017).

Today, workers' compensation formulas are structured around individual state policies, the market value of the work, and the socially constructed value of the worker. Indeed, many injured workers are left to stitch together what they can from safety-net programs like Social Security, Medicare, and Medicaid to cover the costs of on-the-job injuries; however, these supports often prove inadequate. Undocumented workers, ineligible for public assistance despite paying into

  

those programs with each paycheck, turn to family and community to help cover the costs of health care and social reproduction, or forego medical treatment altogether (Horton 2016a). Some insurers are targeting injured undocumented workers by reporting them to ICE for detention and deportation to avoid having to pay their claims (Grabell and Berkes 2017). This perpetuates im/migrant workers' fears of being fired or deported for reporting problems at work (Horton 2016a, 2016b; Stuesse this issue).

There is already a severe undercounting of occupationally injured, ill, and dead workers, in part due to flawed, underfunded, and inconsistent surveillance and inaccessible reporting mechanisms (Grabell 2017; Grabell and Berkes 2015; Leigh et al. 2001; Sered and Fernandopulle 2005, 1; Spieler and Wagner 2014; Woolford et al. 2017). The body counts are even less accurate for im/migrant workers because they often do not control the conditions of their work (Arcury et al. 2002; Horton 2016a; Rao et al. 2004), and do not know their rights or do not have the same rights as other classes of workers (Woolford et al. 2017). Injured im/migrants may also underreport or attempt to work through their injuries or illnesses due to the stigmas of being injured and unable to support their families (Horton 2016a; Unterberger this issue).

In the clinic, employers and health-care providers may discount or disregard the severity of workplace hazards (Arcury et al. 2003; Castillo this issue; Grabell 2015b, 2017; Groeger and Grabell 2015a, 2015b; Holmes 2007; Horton 2016a; Saxton 2013; Stuesse this issue). Additionally, injured im/migrant workers often lack access to or are denied, via coercion, force, fear, geographic remoteness, or racism and ethnocentrism, appropriate and adequate legal, social, and health-care services (Alexander and Fernandez 2014; Castillo this issue; Holmes 2007, 2013; Horton 2016a; Kleinman and Benson 2006; Otero and Preibisch 2010, 2015; Stuesse this issue).

Occupational health researchers, health-care providers, and workers' compensation insurance companies may use reductionist biomedical metrics or ethnocentric ideas about im/migrant workers to determine what does and does not count as a work-related illness, how much their injury or illness is worth monetarily, and whether or not the injury or illness is indeed work-related or a preexisting condition (Holmes 2007, 2013; Horton 2016a; Jain 2006; Saxton 2013; Woolford et al. 2017). For example, Castillo (this issue) observes the mobilization of racist models amongst orthopedic surgeons and workers' compensation physicians attending to injured Latino day-laborer patients in Rhode Island. Furthermore, in workers' compensation, employers' and insurers' obligations end when the health-care provider, often in close dialogue with the insurance company, determines a point of recovery. With certain occupational diseases, like heat stress or stroke (Horton 2016a), the link between the worker's injured or ill body and the conditions of labor are systematically denied or rendered uncertain or unclear. This allows employers, insurance companies, physician providers, and policymakers to place the burdens of responsibility for recovery directly on injured workers, and this can have devastating consequences for families and communities (Grabell 2015e; Grabell and Berkes 2015; Leigh et al. 2001; Unterberger this issue). Certainly, employers' vulnerabilities should not be underestimated or devalued as evident economically and climatically volatile industries like food and agriculture (Benson 2008a, 2008b; Holmes 2007, 2011, 2013; Wells 1996). They are interconnected *but unequal to* im/migrant workers' vulnerabilities, especially when it comes to the power inequalities that privilege profits over people, and the long-term consequences of bodily harm linked to the gendered and ethnic division of im/migrants' labors. Empathy for employers should not foreclose critiques of individual and systemic in/actions that perpetuate the status quo for im/migrant workers.

Thus, while the workers' compensation system has never been great, this cycle of state and federal regulatory rollbacks and cuts leave the safety net, the workers' compensation system, and workers' bodies in chronic states of decompensation. Biomedically, the word *decompensation* refers to the failure of a major organ or the loss of the ability to cope with stress or excess burdens. It can also refer to chronic conditions, like diabetes or heart disease, that can no longer be addressed through routine medical interventions, thus causing permanent and sometimes irreparable harm. The erosion of multiple social supports and the failure of policy makers to create a sustainable, effective, accountable, and interwoven health-care and occupational-safety systems, layers with intensified immigration enforcement, putting undue strain on the most vulnerable and marginalized groups in society. When a person succumbs to a debilitating occupational injury, they must rely more on other parts of their body, putting more weight on one side, for example. They may also become more reliant on other members of their family or community to fill in for their lost roles in income generation and social reproduction. The added roles may make those individuals more susceptible to stress and injury themselves, creating a cycle in which an injury to one becomes an injury to all. This is clear in the case studies featured in this special issue (c.f. Saxton et al. this issue; Stuesse this issue; Unterberger this issue). Adopting the concept of decompensation helps us ethnographically visualize and analyze the multilayered effects of cut and rolled-back support systems, as well as the embodied consequences for

  

immigrant workers, their families, and communities. Workers' labor and embodied experiences are not usually the point of departure for public policies or treatment regimens in the case of occupational injuries and illnesses, and they should be.

**Anthropological Approaches to Work Injuries, Illnesses, and Death**

The chronic overlooking of the environmental, social, and political contexts of workplaces and workers' lives constitutes a serious gap in the epidemiological literature and policies on occupational health (Woolford et al. 2017, 21). Legal, biomedical, and industrial approaches to occupational health rarely attend to the complex ways that structural vulnerabilities produce and exacerbate decompensation (Cartwright and Manderson 2011; Quesada et al. 2011). Instead, they may focus on workers' equipment and individual behaviors and cultures (Castañeda 2010) as the sites of study, intervention, and change (c.f. Bradman et al. 2009; Goldman et al., 2004; Mayer, Flocks, and Monaghan 2010; Monaghan 2011; Monaghan et al. 2011; Salvatore et al. 2008, 2015; WCAHS 2014). Such interventions may prevent or reduce harm, and sometimes change policies, such as with the recent revision of the Environmental Protection Agency Office of Pesticide Programs' of the Farm Worker Protection Standard (US EPA n.d.). However, they do little to challenge the overall injurious cultures of industries, which are rooted in racist capitalist exploitation of women, im/migrants, and workers of color (Horton 2016a; Murray 1982; Pulido 2016; Stuesse 2016). They also neglect how occupational injuries and illnesses layer in the bodies and communities of workers, interacting synergistically with or exacerbating other illnesses or health disparities, and evolving over the life course of the worker (Horton 2016a; Saxton 2013, 2015a).

How can we rethink who and what we research, and how our research is applied via reforms to workers' comp policies and the delivery of direct services to injured im/migrant workers? Critically applied medical and engaged anthropology offers holistic frameworks and insights that could instigate shifts in our lines of inquiry and sites of intervention: from workers' behaviors and bodies to the laws and structures that affect their lives and livelihoods, beyond what is (or is not) "captured in official statistics" (Woolford et al. 2017, 19). The ethnographic approaches reviewed below and contained in this special issue also seek to inspire and create non-injurious, nontoxic, and ultimately noncapitalist economies, cultures, and futures (Burke and Shear 2014), instead of solely privileging the safety, rights, and profitability of consumers, land owners, and industry executives (Clayton et al. 2017; Horton 2016a; Jain 2006; Jaye and Fitzgerald 2010; Navarro 1980; Otero and Preibisch 2010, 2015; Szasz 2007).

Anthropologists have examined how occupational injuries and illnesses, especially those that are invisible, shape workers' subjectivities and identities. The injured must prove to their doctors, lawyers, insurance providers, and employers, as well as to their families and communities, that they are "legitimate sufferers" (Jaye and Fitzgerald 2012). The effects of what Jay and Fitzgerald describe as the "embodied liminalities" of occupational injuries include social stigma, potential exacerbation of health problems while waiting for a legitimating diagnosis, the trials of rehabilitation and treatment, as well as a loss of a sense of self, since the work-injured or ill person can no longer fulfill their social and economic roles in their workplaces, households, or communities (2012, 204). As Horton demonstrates, when workers don't even officially exist because they are *trabajando fantasma* (ghost working) under others' documents, they face even greater challenges in legitimating and receiving health care for their work-related injuries and illnesses, which exacerbates their liminality as undocumented workers (2016a, 2016b).

Structural vulnerabilities for im/migrant workers include relationships between the intensification and consolidation of capitalist production and related management and state labor, criminal, and im/migrant surveillance systems (Heyman 1998; Horton 2016a), shifting political definitions and enforcements of deportability (De Genova 2002, 2005, 2007; Hahamovitch 2013; Horton 2016b; Sisk 2014), and heightened risks and rates of injury, illness, and death amongst affected and afflicted workers all over the world (Grzywacz et al. 2007; Horton 2016a, 2016b; Jaye and Fitzgerald 2012; Otero and Preibisch 2010, 2015; Smith-Nonini 2003, 2011; Stuesse 2016; Williams 1997). For example, Sandy Smith-Nonini observes how meat and migrants are "processed" together on the poultry assembly lines in North Carolina (2003). She links im/migrant dismemberment and death to the deterioration of agricultural economies in both the United States and Mexico intensified under the North American Free Trade Agreement. Williams refers to these processes as "reciprocal degradation" and the "corporeal ramifications of globalization" (1997, 763).

More structurally oriented frameworks within critically applied medical anthropology can help address some of the gaps and erasures in the biomedical and occupational im/migrant health literature. Lenore Manderson and Carolyn Smith-Morris' concept of *chronicities* severs the culturally constructed boundaries between acute and chronic conditions,

  

encouraging researchers to see how illnesses, diseases, and injuries evolve over the life course. This in turn engenders consideration of the political motivations and assumptions that guide disease classification and treatment as well as legal rights and protections.

> The associated representation of conditions as either/or, patterned predictably on a "natural history of disease," denies the fluidity of life states that are simultaneously biological and social . . . Hospital services, insurance companies, and pharmaceutical industries share a particular interest in maintaining this disease paradigm, since existing profits already flow from it. (Manderson and Smith-Morris 2010, 3, 7)

This political boundary work to distinguish acute from chronic conditions and the biomedical tendency to diagnose and treat different diseases (including injuries) in isolation from one another is fundamental to the organization and functioning of the workers' compensation system, which sets concrete starting and ending points for treatment protocols and lost-wage pay and disability schedules. Another ethnographic challenge to problematic constructs of illness and injury include *eco-social* (Krieger 2001) and *syndemic* (Singer and Clair 2003) approaches to health, which emphasizes how social and environmental injustices and inequalities layer within bodies and communities to produce health disparities that synergistically exacerbate one another.

Syndemic patterns, including Holmes' (2013), Horton's (2016a) and Unterberger's (this issue) interviews with occupationally injured and work-stressed Mexican male farmworkers, demonstrate how social pressures and stigmas can intensify other problems, such as substance abuse, gendered shame, difficulties meeting household needs, and the potential for domestic violence. Emily Mendenhall's (2016) work with Mexican and Mexican American women immigrants in Chicago illustrates how the violence and trauma of im/migration, domestic violence, and sexual abuse interact in the body to produce depression and diabetes, which then exacerbate one another within bodies and across generations of women. Horton (2016a) also documented syndemic patterns between heat illness, immigration, and work-related stresses and rage (*coraje)*, heart disease, diabetes, and kidney failure among im/migrant farmworkers in California's Central Valley. And, Nolan Kline's work with Latino immigrant communities in Atlanta (2017, In Press) demonstrates how intensified policing affects access to care, impacting both mental and physical health over time.

Such structurally oriented and socially grounded frameworks within critically applied medical anthropology can help address some of the gaps and erasures in the biomedical and occupational im/migrant health literature. These ethnographic observations and injury and illness narratives challenge the geographic, temporal, and embodied limits that are imposed within the workers' compensation system and can inspire new possibilities for thinking about alternatives to the perpetual state of decompensation of workers, communities, and social, health, and policy infrastructures.

**Toward Recompensation**

Our workers' compensation system is decompensated in many ways. The assumptions that guide occupational and im/migrant health research and interventions in epidemiology, biomedicine, industrial medicine, public health, and other disciplines tend to focus on singular health issues that afflict or affect workers. They also tend to disaggregate individual disparities from the community contexts and structural vulnerabilities in which diseases, illnesses, and injuries emerge. Synergistic diseases or conditions that result in the aftermath of a work-related injury or as occupationally injured or ill im/migrant workers age are often excluded from counts, coverage, or clinical consideration. Insurance company evaluation methods and metrics and standardized treatment protocols are imprecise and inadequate in a number of ways as far as human health is concerned. One cannot always predict the stability of an injury. One cannot always see or measure occupationally induced pain or damaged tissues or diabetes or depression using X-rays. One cannot document the severity of occupational hazardous exposures if blood and urine samples are not taken and analyzed regularly. Even with what seem like short-term improvements, injury symptoms can return and regress throughout life, after all the medical and legal paperwork culminating one's workers' compensation case has been signed and sealed.

The late journalist Elizabeth Grossman recently wondered, "Will workplace safety survive a Trump presidency?" (2016). While one might ask whether or not industrial workplaces have ever really been safe for im/migrant laborers, the authors of this issue are already witnessing the intensified and increased traumas and harms that heightened policing and immigration enforcement; interpersonal and institutional racism, sexism, and classism; and cuts to social services and health safety nets (or even the threats of these cuts) are having on the everyday lives of im/migrant workers and their families. Health care, labor, social welfare, environment, and immigration intersect and sometimes contradict one another in practice if and when they are enforced and upheld. While agricultural and undocumented workers have been

  

historically excluded from a number of legal benefits and protections, the pro-business culture of the Trump administration could further imperil small gains made in previous years, such as revisions to the EPA Farm Worker Protection Standard in 2015 and the development of new injury and wage theft reporting mechanisms (Grossman 2016). These ongoing and deepening challenges require urgent anthropological and public attention, not only through research but through advocacy, engagement, and activism with work-injured and ill im/migrant laborers. As Charles Levenstein and Carlos Siquieros suggest, we need to be "[allies] in the struggle, to stop corporate dominance…and ensure the health and safety of all communities" (2017, 7).

Given all that is at stake, critical medical and engaged anthropologists have a responsibility to challenge, intellectually and tactically, all forms of market-based medicine (Rylko-Bauer and Farmer 2002; Scheper-Hughes 1990). This includes the workers' compensation system with its irregular state-to-state laws and private insurance companies and its universalist formulas and protocols used to diagnose and treat injured workers. These structures, policies, and practices are inappropriate to the task of healing work-injured and ill im/migrant workers and, in many cases, end up doing more harm in a profession that pledges to do no harm. It also requires us to fight to maintain existing protections, however, insufficient. As former Cal-OSHA Deputy Chief for Health Deborah Gold observes, commenting on the regressive policy shifts of 2017, "Workers cannot remain mobilized on the same issues forever. We need to be able to rely on what we have already accomplished so that we can move on to other issues" (Gold 2017). Such battles may be personally risky and exhausting, but past worker struggles illustrate that great sacrifices have been made to move labor, environmental, and social protections forward under the law (Levenstein and Siqueiros 2017).

The workers' compensation system intensifies biomedicine's fragmentation of bodies into their component parts, each associated with a monetary or reimbursement value (Grabell 2015a, 2017; Groeger and Grabell 2015a, 2015b) and a standard course of action that will take place over a predetermined time frame. Through our work, it has become increasingly difficult for us to think about different health problems and systemic inequalities in isolation from one another. Im/migrant workers' insights can produce new frameworks of the political economy, ecology, and critical medical anthropology of injuries, as well as potential alternative approaches to labor and occupational health that are more patient-centered and community-based. Workers' decompensation produces an "an injury to one" becomes "an injury to all" when we consider the ripple effects work-related injuries and illnesses have on workers' transnational family and community networks and their life courses. We must consider how healthy, sustainable food systems should apply such values to include food systems laborers (Gray 2013; Gray et al. 2017; Horton 2016a).

At present, syndemics, chronicities, eco-social, and worker-centered approaches to health have not been widely incorporated into biomedical or occupational health practice. These frameworks provide more nuanced and holistic (Weaver and Mendenhall 2014) approaches to the multi-layered lives of occupationally sick and injured im/migrant workers, and challenge the temporal limits of the ethnographic present and the clinical encounter. Thus, in addition to new ways of thinking about the connections between labor, immigration, and health, anthropologists may apply their insights to develop ways of incorporating syndemics and chronicities into biomedicine. This could include furthering the institutionalization of family and community practice in clinics serving im/migrant communities, and cross-training health-care providers in medicine as well as social science, environmental health, and region- and community-specific histories. Anthropologists studying injured im/migrants should make longer term commitments in those communities and take care to ensure that projects carefully align research agendas and methods with those of community-based and activist organizations working with im/migrant workers (Saxton 2015b; Stuesse 2015; Stuesse and Coleman 2014). Ethically engaged research requires committed relationships with research participants that last even well after one's fieldwork is complete (Horton 2016a). It will also require us to do more to change the sites of our interventions from the bodies and behaviors of workers to the structures and systems that chronically and perpetually injure and kill them. Anthropologists can find ways to include workers in policy and decision-making initiatives and design creative strategies to instigate cultural and paradigm shifts that value workers' lives over corporate bottom lines (Woolford et al. 2017, 22). Our challenge as anthropologists, then, aside from documenting and analyzing these patterns, is to study up these systems *and* incorporate our models into everyday health care, policy, and occupational practice for the most structurally vulnerable and marginalized communities.

## Notes

1 We use the phrase *im/migrant* to distinguish between people who migrate from place to place within or between countries, and those who stay in place after their initial migration (Castañeda 2010201020102010). We use immigrant and immigration to refer to public policies and attitudes.

  

2 Lobbying for workers' comp reform also comes from large corporations in other industries, as well as industry associations, as these are increasingly permitted to self-insure. Cutting out the third-party carrier exposes corporations to risk associated with high claims costs and high deductibles, but these are mitigated by their ability to "contain" these costs (Rousmaniere 2015, 9) using sophisticated systems that include the repression of injured workers' claims.

3 Many studies substantiate the dramatic extent to which the costs of workplace injury (and therefore, corporate profit) are now being subsidized by workers, taxpayers, and private health insurers at a rate as high as 79 percent of costs by some accounts (Groenewold and Baron 2013; Leigh 2011; Leigh and Marcin 2012; Michaels 2015). A 2015 OSHA report thoroughly reviews the state of the field, highlighting studies that consider Social Security Disability Insurance (SSDI) and Medicare usage among injured workers to determine the extent to which these programs are subsidizing the workers' comp system (Michaels 2015). In one national study, the authors found that SSDI and Medicare together subsidized workplace injuries to the tune of $33 billion in the year 2001 (Reville and Schoeni 2004). Among disabled study participants who reported their condition was caused by work, noted OSHA, "only 12% had *ever* received workers' compensation benefits, while 29% were currently enrolled in SSDI," (Michaels 2015, 10). Another study (O'Leary et al. 2012) found that "seven percent of the roughly one million people who became new SSDI beneficiaries in 2010 became disabled as a result of a workplace injury," and that each year this group increases SSDI expenditures by roughly $12 billion ($24 billion if Medicare is included), straining the programs' ability to provide adequate benefits to those who need them (Michaels 2015, 11). Xuguang Guo and John Burton, Jr.'s work concludes that the application rate for SSDI benefits increased as a result of the tightening of workers' comp eligibility and benefits in the 1990s (2012).

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