

***SOCIOLISMO* AND THE UNDERGROUND CLINIC: THE INFORMAL ECONOMY AND HEALTH SERVICES IN CUBA**

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Medical historians, anthropologists, physicians and public health researchers have all written favorable assessments of the Castro regime's health initiatives. The 1959 revolution and transition to socialism have been credited with rapidly transforming Cuba's mortality profile (Danielson, 1977; Danielson, 1979; Danielson, 1981; Elling, 1989; Gilpin, 1991; Waitzkin, 1983), eliminating class-based disparities in health status and access to health care (Chomsky, 2000; Feinsilver, 1993; Nayeri, 1995; Singer and Baer, 1995; Martínez and Whiteford, 2000; Susser, 1993) and "revolutionizing" medical practice and medical science in a number of positive ways (Baer, Singer and Johnson, 1986; Feinsilver, 1993; de Brun and Elling, 1987; Guttmacher, 1989; Guttmacher and Danielson 1979; Santana, 1988; Swanson et al, 1995; Waitzkin and Britt, 1989; Waitzkin et al, 1997; Warman, 2001). Even with the debilitating economic crisis brought on by the collapse of the Soviet Union, some scholars continue to argue that Cuba's health system remains superior to neighboring countries such as the Dominican Republic (Acosta, 1997; Chomsky, 2000; Waitzkin et al, 1998; Whiteford, 2000; Whiteford and Martínez, 2001).

THE RESEARCH

In 1996, I traveled to Havana for a year of dissertation field research to look at this transformation of health and medicine. My goal was to use anthropological research methods—long term residence, participant observation, case studies, ethnographic interviews—to study the transformation of health and medicine in socialist Cuba. There would be three

parts to the project. The first phase would be living in a local community, with the goal of learning more about Cuban culture, and to observe the ways people behaved with respect to health and disease in their everyday lives, outside of the formal health sector. The second phase of the project would consist of formal clinic observations in at least two family doctor clinics. I would shadow these physicians during the course of their workdays so that I could get a better sense of what family medicine was like in practice. I would also conduct formal and informal interviews with family doctors, soliciting their personal reflections on Cuba's unique social medicine programs. And finally, from the local community and the clinics, I would draw a series of case studies that best exemplified the social and cultural dynamics of Cuban health care. As originally conceptualized, the project was intended to document (and highlight) Cuba's profound achievements in social medicine.

During my field research, my opinion of the Cuban health care system underwent a dramatic transformation. The idealistic, egalitarian system I had read about in the scholarly literature bore little resemblance to the conditions I observed in my study communities. While many of the individual doctors I worked with were dedicated and caring professionals, they were forced to work within a system that was deeply politicized, authoritarian, and repressive. Furthermore, it was clear that the partial privatization of the Cuban economy in the 1990s created many new planes of socioeconomic stratification. These new inequalities have had a number of negative effects on

environmental conditions and population health. In at least one instance (the epidemic of dengue fever that struck Oriente Province in the summer of 1997), the Cuban government has chosen to respond to these health challenges with authoritarian repression and denial rather than appropriate public health prevention measures (see Mendoza and Fuentes, 2001).

These experiences led me to develop a much more critical perspective on Cuba's health care system. While I still regard the expansion of hospitals and health clinics that occurred after 1959 as positive, I also feel that contemporary health indicators are unreliable, and that the bureaucratic, authoritarian aspects of clinical medicine can lead to negative experiences for doctors and patients, as well as poor health outcomes. In other words, the field research made me aware of how positive statistical health indicators can be created through a variety of means, some of which may be quite subjectively unpleasant for doctors and patients. Given how historically closed Cuba has been to outside researchers, it is impossible to empirically investigate the negative aspects of Cuban health care first hand. My qualitative research on the island, however, did make it possible to explore (albeit in a fragmented and anecdotal way) some individual medical clinics and patient narratives that exemplify the ambiguities of Cuba's community medicine.

This paper will discuss the practice of family medicine as I observed it in two urban communities in Cuba in the late 1990s. A detailed qualitative overview of family medical practice will be followed by a discussion of the way individual community residents described their experiences with the health care system. These narratives suggest that many Cubans preferentially seek health care in the informal sector as a way to subvert the material shortages and political surveillance associated with formal medical practice. A final section will discuss the implications of these trends for control of both infectious and chronic diseases, and speculate on how they may affect health in the impending post-Castro era.

FAMILY MEDICINE

Cuban family doctor clinics are most often located in small, white, prefabricated concrete two-story dwellings, known as *consultorios*, with identical red-trimmed balconies and a small yellow plaque attached to the door that reads, "Médico de la Familia." Each *consultorio* is intended to serve a patient population of between 500–700 individuals (or 120–150 families). These clinics are located at regular intervals throughout the city. The national Ministry of Health (MINSAP) designed the *consultorio* to be used both as a professional and a personal space—above each clinic is a small apartment, and the family doctor is expected to live there and be on call for his or her patients twenty-four hours a day.

One enters the *consultorio* through the front door into a small waiting room. The ceilings are high, and the rooms are kept tightly shuttered to keep out the sun. There are no fans or air conditioning. Two (usually dilapidated) wooden benches face each other underneath peeling walls decorated with faded bulletin boards featuring collages (snipped from old magazines) designed to illustrate the importance of breast-feeding, nutrition, blood pressure control, or other general areas of health promotion.

Through a small doorway behind the waiting area there is a space that serves as both a laboratory and consulting room. On the left hand side of this room there is a small desk with two chairs in front of it, and on the right is a large open counter space, usually with an autoclave or other medical equipment. A row of cabinets containing files and medical charts line one wall. Behind this area is a final, private consulting space shielded by a curtain. This area usually contains an examination table and a scale. Often this area is also used to store used or broken equipment.

The upstairs area is the residential space, laid out as a small, two-bedroom apartment. Ideally, the family doctor lives above her or his clinic, in order to participate in the social life of the community, and to be available to patients in the event of an emergency. Not all doctors, however, choose to live above their *consultorios*. Given the housing shortages in Cuba, these residential spaces are sometimes appropriated by other health care professionals, whose housing sit-

uation may be more urgent the doctor's. Some physicians, on the other hand, voluntarily cede the space to others, in order to limit the demands of being in residence and thus on call twenty-four hours a day. Doctors who opt to live above their clinics may also choose to divide their time between the clinic living space and their familial (i.e., parents) homes as a way of carving out some private time for themselves.

MEDICAL PRACTICE

My first impressions after observing several family doctors at work was that the idealistic descriptions of Cuba's "revolutionary" medicine I had read in the academic literature were accurate—the system and the doctors themselves seemed quite impressive. The doctors, for instance, maintain an intensely social orientation to health and medicine, know all of their patients personally, and interact freely with them in a variety of social/medical contexts.

Another very admirable dimension of family medical practice in Cuba, as compared with the United States, is the complete absence of financial, insurance, or other support personnel in the clinics. *Consultorios* are staffed only by a doctor and a nurse. There are no receptionists, billing clerks, insurance forms, or appointments. Patients enter through the front door, take their place in line, and wait until the doctor calls to enter the consultation area. Or, if there is no one in the waiting area, patients simply walk back to the consulting area themselves. Patients are not required to describe their symptoms to a nurse or other paraprofessional prior to visiting with the doctor.

The complete absence of any bureaucratic intermediaries between doctor and patient, combined with the fact that the doctors often practice in their own residential neighborhoods, creates an atmosphere of informality that often appears (from a North American point of view) quite unusual. Family medical practice in Cuba is not conducted in a solitary or controlled environment, but is instead often a public, social event. Consultations are routinely interrupted by social visits, and social interactions with health care

professionals (in their homes, for instance) often take on the character of medical consultations.

In this sense, the contrast with a North American family practice clinic is quite marked. It is difficult to imagine, for instance, an American physician interrupting a consultation with a patient and inviting in a host of visiting relatives from Miami to have coffee with him (and the patient) in the consulting area. It is also difficult to imagine an American physician allowing patients to approach her on the street and ask for medical advice or informal consultations. Yet in Cuba, such occurrences are an integral part of the daily routine of the family doctor. Social visits overlap with medical visits, and the doctor is simultaneously viewed in terms of his or her social and professional roles.

The following description, taken from my first day of clinic observations, offers a glimpse into the uniquely social character of family medical practice in Cuba today.

Dr. Lena Rodríguez:¹ Dr. Rodríguez is a quiet, intellectual woman of forty-five. She has been a family doctor for five years and practices in a slightly dilapidated, lower-income neighborhood in the northern section of Santiago. She is a native of Santiago, and divides her non-work hours between the living space above her clinic, and her father's house, which is just a few blocks away. Her posted consulting hours are from 8–12, Monday through Friday, with afternoons reserved for house calls, polyclinic, or hospital visits.

I arrived at the clinic for my first day of observation at 9 am, worried that my presence might be considered intrusive or unwelcome, or that patients would be inhibited about speaking openly in the presence of a foreigner. After only an hour or so of observing, however, I realized that visitors are quite a common occurrence in family doctor clinics. My status as a foreigner inevitably prompted some curious questions, but for the most part I was able to blend into the background and be relatively unobtrusive. The consulting room always seemed to be full of people

1. All names and other identifying information have been changed to protect the anonymity of these informants.

(at one point I counted over seven), all engaged in multiple overlapping conversations with the doctor, the nurse, and with each other about their assorted health concerns. New patients dropped by and seemed to think nothing of interrupting the doctor in the middle of a consultation in order to clarify paperwork, check on prescriptions, or just to stop in and say hello.

At one point early in the morning, for instance, an older man came into the consulting area and immediately began to expound on the difficulty he was experiencing trying to quit smoking. An elderly woman who had stopped by to inquire about her husband's lab results joined in the discussion with him, and the two of them sat in the consulting area with the doctor for well over half an hour, all of us engaged in a general discussion of the health effects of smoking and the suffering our assorted friends, family, and neighbors had experienced with regard to cigarettes. During this talk, another woman arrived to get her blood pressure checked and she joined in the discussion as well. After a few moments, Dr. Rodríguez's nurse brought in a tray of coffee, and as everyone sat sipping from their tiny little espresso cups three neighborhood children stopped by to show off the contents of a new care package that one little girl's father had just sent from the United States.

Everyone took turns admiring the dresses, slippers, and toys while the doctor quietly asked the girls to take away the coffee cups and check on her dog upstairs. Several people departed after finishing their coffee, to be replaced by two new patients and a social work trainee clutching a handful of paperwork. As the doctor started making phone calls to try and resolve the bureaucratic problems with the social work student, yet another group of children came running in for a quick visit. One little girl walked up to the doctor and climbed into her lap for a quick snuggle before she was shooed away by the nurse.

"Is she yours?" I asked the doctor, trying to be heard over the din.

"Oh, no. She lives in the neighborhood," Dr. Rodríguez smiled down at the little girl. "But she comes

in all the time." The little girl smiled shyly, wiggled out of the doctor's lap and ran out the door.

This pattern of patient care and social calls continued throughout the day. Patients came by to have prescriptions refilled, to chat, and to have their blood pressure checked. One woman came by to report a shipment of soap had just arrived in the state stores (provoking a massive exodus from the waiting room).

The final patient of the day also provided a unique glimpse into the way family doctors view their role in managing their patients' emotional distress. As the afternoon drew to a close, the doctor, the nurse, and I sat in the *consultorio* office talking and laughing over some of the more chaotic situations that emerged over the course of the afternoon. Just as we were getting ready to leave, a middle-aged man peered tentatively around the partition from the waiting room. As soon as they saw him, Dr. Rodríguez and her nurse hailed him enthusiastically. "¡Ai, señor Gallindez, come in," they exclaimed. "You haven't been by in forever. And how nice you look today. Doesn't he look nice?"

Sensing that it was somehow the appropriate thing to do, I concurred, although I couldn't help but think señor Gallindez was a little strange-looking myself. His hair had been dyed a very unnatural shade of black and he was reeking of some terrible cologne. He also seemed very anxious, but Dr. Rodríguez and her nurse continued to fawn over him.

Señor Gallindez's spirits seemed to lift during this discussion, but soon he looked downcast again. "But *Doctora*," he said nervously, "I'm still worried about not being able to go back to work. I feel bad about not being able to work." Doctor Rodríguez looked at him incredulously. "But you're an artist," she exclaimed. "You need some time off, some time away from work so that you can create great things. Now don't worry about working. Just relax. Concentrate on your art." Señor Gallindez seemed somewhat reassured by this, and seemed visibly more relaxed as he took his leave.

After he was gone, the doctor shook her head sadly. "¡Ai, el pobre. *Esta muy enfermo de los nervios*," she sighed. In Cuba to be "enfermo de los nervios," or

“sick with nerves,” generally implies the person is suffering some sort of psychological or psychiatric disorder. I have heard the phrase used to describe everything ranging from short outbursts of temper, to psychotic or violent behavior. “The poor thing,” the doctor continued. “He spends hours and hours every day standing in front of the mirror tending to his hair. He’s completely obsessive about his appearance to the point where he can’t even work. He comes by the clinic periodically and we try and give him lots of compliments so that he’ll feel better about himself.” She sighed. “You know, sometimes you just have to do whatever little things you can to make them [the patients] feel better...to help them alleviate all the stresses they are under.” She laughed sadly. “Oh, I’ve tried all sorts of things. I did acupuncture sessions, and even massage with some patients. Then for a while on Saturday mornings I’d invite people in for a little Japanese tea ceremony. You know, just so they have a quiet place to go and escape from their problems once in a while.” She sighed again. “You know, *aquí, no es fácil*.” [life here is not easy].

This first day of clinic observation made quite an impression on me. Accustomed to the air of cloistered formality so prevalent in American medical establishments, I found the openness and general air of festivity in Dr. Rodríguez’s clinic to be quite heartwarming. These nontraditional medical interventions might not necessarily be clinically effective in terms of having a measurable effect on the underlying (physical or emotional) pathology that produces the stress on the individual. But on the other hand, they do seem to represent powerful examples of the ways doctors can simply *make people feel better*, even if they are unable to effect clinical cures.

My subsequent days of observation in other family doctor clinics led me to believe that the intensely social and informal style of Dr. Rodríguez was fairly representative of family medical practice in Cuba. All the family doctors I interviewed and observed maintained a similarly informal atmosphere in their clinical encounters, and a parallel merging of their social and professional lives. On the occasions I visited these individuals in their homes, for instance, our social visits would immediately take on the character of

medical consultations if I happened to mention I was suffering from any kind of health problem. Every doctor I knew always appeared ready and willing to “consult” at any time, either inside or outside the clinic.

Conversely, patients also felt free to ask for consultations at any time. One day I stopped by to visit Dr. Rodríguez at her parent’s house. She arrived almost thirty minutes late, laughing at the way she was continually waylaid by neighbors seeking advice about some complaint or another as they saw her walk by on the street. “Sometimes it takes her an hour just to walk home,” her mother said wearily.

“Oh, I know,” Dr. Rodríguez laughed. “Sometimes they come up to me and say, ‘Look *Doctora*, I have a pain right here.’” She pointed to her side. “And I have to tell them, ‘Please, I can’t really examine you in the middle of the street like this, come to the clinic,’ and they say, ‘But doctor, it will only take a minute, and then they invite me in for coffee and then the whole afternoon is gone.’”

On the few occasions I was able to accompany family doctors on their afternoon house calls, I was surprised to see that the intensely social nature of the house call meant that each visit took up a minimum of an hour, and sometimes stretched as long as two, even for something as simple and basic as a blood pressure check for a hypertensive patient. Coffee or some other refreshment was always served on a doily-lined tray, in keeping with the formality accorded a honored *visita*. Often the entire household was convened to visit with the doctor, who might spend ninety percent of her or his time in the house in social rather than medical conversation.

Corresponding with this intensely social orientation in medical practice is a philosophy of patient care that emphasizes the importance of communication and simple acts or gestures of caring for patients. The organizational structure of health services in Cuba (high availability of physicians, no cost to patients at point of service) greatly facilitates this approach. Unstructured clinic time means that doctors are free to engage in a range of curing and caring activities that might be considered inappropriate or non-medical

(though not necessarily undesirable) by American standards. One family doctor, for instance, summarized his philosophy of patient care to me as follows,

If I have a hypertensive patient who comes in for a blood pressure check and it's [the blood pressure] high, I usually tell him it's only a little bit high. Then I put the stethoscope away, and turn and give him all my attention. I ask him how his family is, talk to him, see what kind of stresses are going on. Then towards the end I'll take his blood pressure again, and the second time it's always much lower. Just having the chance to sit and talk about his problems with someone makes a big difference. I like to do things like that for my patients. Sometimes you just have to put the stethoscope away, put all of the medical stuff away, and just be a friend, or a counselor. They always walk away feeling better. That isn't science, that's just humanity. I've seen movies about American medical students, and it looks like they have everything—all the latest equipment, all the best training, but that isn't necessarily the best way to make someone a good doctor. In our six years of medical school, we start from the very first year dealing with patients—we have to take a class called society and health that explains all the relationships between sociology and medicine.

Patients also seemed to feel little inhibition in sharing their narratives of trauma or suffering with their doctors. On several occasions I observed patients who specifically sought out a consultation with their family doctor just to talk about life crises or family problems. During these encounters the doctors (as well as any extraneous people in the consulting area) were inevitably attentive and understanding, and there seemed to be no indication that this was considered any way inappropriate for a medical consultation.

FAMILY MEDICINE, SOCIAL PROBLEMS AND SOCIAL CONTROL

How are social problems addressed by Cuban family doctors? Previous researchers have understood these dimensions of Cuban health care in terms of the linkages between primary care providers and “revolutionary” or mass organizations such as the Committees for the Defense of the Revolution (CDR), trade unions, or other social service providers who work

together to provide integrative care for social, psychological and physiological complaints (Waitzkin and Britt, 1989).

My observations and interviews with mass organizations such as the CDR and Cuban family physicians, however, has led me to conclude that while some “social problems” are openly addressed in doctor-patient encounters, others are not. In fact, many significant social problems appear to be suppressed or otherwise rendered invisible by the institutions that are ostensibly in place to alleviate them. These findings are important since they contradict much of the established literature on the reconfiguration of the doctor-patient relationship in Cuba and other socialist societies.

As illustrated in the previous description of family medical practice, patients seem to feel few inhibitions about sharing their narratives of suffering or psychological distress with their family doctors. My community ethnography, however, made me realize that many of these narratives of suffering are often left incomplete. Patients appear to deliberately censor their conversations with doctors to eliminate any comments that could be interpreted to imply social or political dissent. In other words, there are certain very fundamental social inequalities and contradictions that are taboo to acknowledge in any public context, medical or otherwise. In fact, such expressions of dissent or criticism are themselves defined as “social problems” by the Cuban government, and family doctors and mass organizations are expected to “treat” them accordingly.

Dissent, of course, is not the only social problem these organizations are geared toward resolving, and many of them do participate in public health campaigns and health outreach to their communities. But still, the activist agenda of the family doctor and the mass organizations appears to be determined entirely from above, and their role in the community seems to be primarily to reiterate the proclamations of the leadership rather than actively formulating social/medical policy at the local level.

One key dimension of the family doctor's role (as opposed to the mass organizations) with respect to

identifying social problems is the use of the community health survey to monitor political beliefs at the household level. The family doctor health survey form has a space specifically marked for the doctor to comment on the household's (or individual's) "political and social integration." In this case "political integration" refers to such activities as participation in volunteer labor brigades, membership in mass organizations like the Federation of Cuban Women (FMC) or the CDR, as well as an exemplary work record. This survey overlaps with other workplace and community programs of social and political surveillance. The CDR, for instance, polices neighborhoods for any potentially counterrevolutionary activities, while workplace vigilance organizations monitor employees and mandate their participation in volunteer labor brigades, political rallies, and parades.

This unique political function of family medicine was further underscored at a local election I was able to attend in Santiago. The election itself took place in front of a local family doctor *consultorio*, and the three neighborhood family doctors stood on the dais together with two local political officials. Each family doctor played a role in terms of organizing and executing this event, and each was expected to give a brief political speech (in this case emphasizing the importance of defending Cuba against enemy imperialists). The inclusion of these physicians in this event was not accidental, but rather served to underscore the place of family doctors with respect to other institutions of social and political control.

This political role of the family doctor is also illustrated by the militaristic rhetoric used in medical textbooks and other health publications about the ideology and practice of socialist medicine. One introductory textbook, for instance (Rigol et al, 1994:28), described the role of the "revolutionary" doctor as emblematic of *un militante de la salud* ("a health militant"). Another source revealed that the standard medical school curriculum includes several semesters of mandatory classes in "preparación militar"—or military training (MINSAP, 1979). This training is designed to underscore the role of the

physician in the war against imperialism and underdevelopment.

This military training also emphasizes discipline, hierarchy and obedience to authority for all doctors. The family doctor, for instance, is supposed to comport himself or herself as an exceptionally ideal revolutionary—fervent, loyal, dedicated and altruistic, and of course, completely intolerant of dissidents or counterrevolutionaries. One published description of the ideal revolutionary doctor included such personal traits as "simplicity, modesty, and honor" as well as "patriotic-military preparation necessary for the defense of the revolution and socialism on the national or international scale" (MINSAP, 1979:39). In terms of specific ideology, the physician is expected to embrace Marxist-Leninist theory and an appropriately proletarian attitude,

In the formation of this [ideal revolutionary] doctor, with respect to political aspects, we must train him to confront the problems of the country: the defense of the fatherland, the call of internationalism, the development of a proletariat consciousness, the adoption of working class interests, so that he begins to have a clear conception of his role as a scientific worker, without elitist positions and with a just valorization of the workers who produce the material wealth...of society (MINSAP, 1979:56).

In this sense, the ability of family doctors and mass organizations to identify and respond to pressing social or public health concerns is often contingent on whether these problems are acknowledged by those in power. In the early 1960s, for example, health and sanitation issues were considered vitally important social problems that required intensive neighborhood mobilization. At present, however, health and sanitation programs to combat infectious disease appear to have lapsed. In many neighborhoods in Santiago and Havana trash removal is haphazard, mosquito eradication lax, sewage disposal is an ongoing problem, and the drinking water is quite contaminated. None of these "social problems," however, appear to be prioritized by the Cuban leadership. As a result, neither family doctors nor mass organizations could embark on large scale improvements since to do so without

an official mandate would constitute an act of discipline.

In other words, to publicly identify local health problems that have not been officially acknowledged by the revolutionary leadership is understood to constitute criticism or insubordination. In the case of the dengue epidemic in Santiago in 1997, for instance, family doctors were originally prohibited from diagnosing dengue in their patients, who were instead told they had a virus. Correspondingly, there was only minimal attention paid to mosquito eradication by mass organizations like the CDR since officially there was no epidemic underway. For the mass organizations to instigate an aggressive public health campaign to combat a nonexistent epidemic would be understood as quite irrational, not to mention potentially subversive. It was only after the leadership officially acknowledged the epidemic that a concerted CDR mosquito eradication campaign was undertaken.

One of the main reasons for the initial suppression of this epidemic was that in the spring of 1997, *Granma*, the official daily newspaper of the Cuban Communist Party reported, “hemorrhagic dengue, labeled by the World Health Organization as one of the emerging infectious diseases in Latin American and the Caribbean, was eradicated in 1981 from our environment and *since then not one single case of this illness has been reported*” (*Granma*, April, 17, 1997, emphasis added). In other words, if the leadership proclaimed dengue had been eradicated in Cuba, then any doctor who diagnosed a patient with dengue, or any CDR leader who attempted to undertake aggressive mosquito eradication to control the epidemic, would be guilty of an act of indiscipline. These dynamics were quite apparent in the case of Dr. Dessy Mendoza, a dissident Santiago physician who was sentenced to eight years in prison for publicly criticizing the Cuban government’s handling of the 1997 epidemic (see Mendoza and Fuentes, 2001).

What this case shows is that health issues or social problems that might potentially contradict the official proclamations of the revolutionary leadership, for instance, are suppressed. The extent to which

similar events have taken place with respect to other infectious diseases that have been declared to be eradicated in Cuba, of course, remains unknown. But given the very visible deterioration of public health and sanitation services in the Special Period, it seems likely that other infectious diseases such as gastritis, enteritis and other waterborne diseases, along with a number of sexually transmitted diseases (from the dramatic increase in prostitution and sex tourism in Cuba in the 1990s), have probably experienced a significant resurgence in recent years. If they are acknowledged by those in power, however, individual doctors and the mass organizations cannot embark on any campaign to control them without being subject to similar acts of retribution.

The family doctor, therefore, would seem to occupy a somewhat ambiguous position in Cuba. On the one hand, by virtue of her or his daily contact and intimacy with the community, the family doctor has the potential to gain an unprecedented level of popular trust and confidence. On the other hand, the political dimensions of family medical practice can create an atmosphere of tension towards family doctors in general, since patients realize that in some contexts, doctors are obligated to act as informers.

There is no right to privacy in the physician-patient relationship in Cuba, no patients’ right of informed consent, no right to refuse treatment, and no right to protest or sue for malpractice. As a result, medical care has the potential to be intensely dehumanizing. To elaborate, these values (privacy, autonomy, and individualism) form the cornerstone of medical ethics as understood in most Western health systems (Brock, 1987). Privacy and autonomy underlie the practice of informed consent, as well as other legal codes that ostensibly protect patients from potential abuses (unwanted treatment, inappropriate treatment, or untested experimental treatment) of modern medicine. Legislation giving patients these rights was enacted in the United States as a deliberate response to the perceived excesses and ethical lapses of medicine in the 1940s and 1950s. In Cuba, however, values such as privacy and individualism are rejected by the socialist regime as “bourgeois values,” contrary to the collective ethos of socialism. As a result of this

devaluation of autonomy and individuality, the health care system in Cuba is often quite paternalistic and authoritarian, and politics intrude into medical practice in a number of subtle and overt ways.

The extent to which family doctors actually use their community access to seek out counterrevolutionaries appears to be highly variable. Some doctors are rumored to actively inform on their patients, but others undertake only the thinnest veneer of revolutionary participation. In one clinic, for instance, I observed several patients unselfconsciously confide potentially “subversive” activities or sentiments (mostly involving household activities in the informal economy) to their family doctor, who appeared to sympathize accordingly. It was clear that the relationship of trust and caring between these doctors and their patients was forged out of their mutual ability to protect these confidences. On the other hand, I also knew other physicians (and patients) who considered it part of their duty to the revolution to use their position as community insiders entirely to further the political agenda of the government.

After observing one family doctor berate a pregnant woman for failing to show up for a scheduled ultrasound, for instance, I questioned her (the doctor) about Cuba’s maternal health programs. “What happens if an ultrasound shows some fetal abnormalities?” I asked her. “The mother would have an abortion,” the doctor replied casually. “Really? Why?” I asked. “Otherwise it might raise the infant mortality rate,” she replied automatically.

What this exchange reveals is the way in which this particular physician interpreted her role with respect to the dual obligations of patient care and political duty. If the mother in this case resisted or refused to terminate a potentially problematic pregnancy, it could negatively affect Cuba’s infant mortality statistics. Cuba’s Ministry of Health has made preservation of the infant mortality rate one of its most central goals for all medical personnel, and individual doctors are supposed to organize their clinical interventions to maximize these national public health goals. If the patient appears to resist these interventions, the doctor’s role is ostensibly to resolve the issue in the interest of the revolution (i.e., as defined

by the Ministry of Health). Of course, many physicians and patients actively (and passively) resist the kind of dehumanized medical practice that results from this system.

SOCIALIZMO AND THE UNDERGROUND CLINIC

While some people maintain close personal and professional relationships with their family doctors, others seem to view family doctors as lacking in prestige or expertise as compared to medical specialists. Several people dismissed my interest in family doctors by saying, “But why do you want to study them? They’re the people who couldn’t do any better in medical school so they became family doctors. Most of them don’t really know very much. The best doctors are all in the hospitals.”

This prejudice, combined with the inherent ambiguities of the family doctor’s position in the community, has facilitated the development of a parallel system of informal health services based on traditional kinship ties and networks of patronage and reciprocity. In other words, many people simply choose to bypass their family doctors and the formal system of health services in favor of informally consulting with friends or relatives who are both physicians and *gente de confianza* or *socios* about their health problems.

In fact, most (if not all) of the patient narratives I collected reflected at least some degree of involvement with this dual system of health services. One medical professional I knew, for instance, jokingly made a comparison between Cuba and the United States with regard to this kind of health seeking behavior,

I have a cousin who works in a hospital in Miami, and she always said the biggest difference between Cubans and Americans in the hospital is that Americans will look to their doctor to explain to them what is going on. The doctor explains things to an American, and he will sit there and listen, and afterwards be completely satisfied with the explanation. But Cubans will listen politely to what the doctor tells them, but they don’t believe a word of it. After they talk to the doctor they run tearing around the hospital looking for a friend or relative who will tell them what’s really going on.

In other words, the tendency to rely on informal systems and family networks for medical consultations seems to be driven by the historical importance of kinship and patron-client relations in Cuba, and reinforced by the political and bureaucratized nature of medical practice under socialism. A number of reports from the former Soviet Union indicate that a similar tendency was also quite widespread (Feshbach and Friendly, 1992; Ledeneva, 1998; Knaus, 1981). As Ledeneva (1998:29) has described,

Getting into a good hospital, a hospital already filled to capacity, or the hospital with the right specialization for one's illness still required *blat*.² Surgical operations at the best medical centres were, and still are, organized by *blat*: "When I had this problem my friend arranged that I be hospitalized in the regional clinic where he worked and not in the city hospital to which I was affiliated." To arrange an appointment with a well known doctor also implied a personal contact or acquaintance. Doctors were important people with whom to cultivate relationships because, in addition to providing access to hospital beds, *blat* with the doctor could sometimes make the difference between whether he or she listened seriously to the patient and gave a good diagnosis during a visit or only dealt with the matter perfunctorily.

These dynamics appear to characterize the Cuban health care system as well. In the neighborhoods where I lived in Havana and Santiago, for instance, no one I knew who fell ill ever consulted his or her family doctor. Instead, they chose to solicit medical advice from friends, neighbors, and/or family members. Sometimes these individuals were health professionals, and sometimes not.

One woman who lived down the street from me, for example, developed a respiratory infection and diagnosed herself alternately with a cold, tonsillitis, and bronchitis. She self-medicated with folk remedies recommended by her (nonprofessional) neighbors, and gave herself an injection of penicillin (provided by a friend of hers who worked at a pharmacy). She also complied with common Cuban folk wisdom and

tried to refrain from contact with cold air, cold water, or anything that might involve a temperature change for the body.

After several days without much improvement, she went to the hospital to visit her sister (who was having an eye operation) and informally requested a tetracycline injection and throat culture from a doctor there who was a friend of the family. Then, when she got home, she called her daughter (who is a doctor in Havana) and solicited advice as well. As best as I could discern, she followed everyone's advice to some extent. When I asked her why she didn't consult with her family doctor (who was only four blocks away), she said she simply didn't feel the need.

Pharmaceuticals are also exchanged along these informal networks. One day, I was sitting on the front porch visiting with a neighbor when a woman who lived up the street came by to ask me to help her sort through some medicine her family had sent from Miami. She brought an enormous plastic bag full of wholesale pharmaceutical packages (not prescription vials), which had no inserts or dosage instructions. None of them were medications I had ever heard of, and most of them appeared to be out of date. I tried to caution her against taking them without at least finding out what they were for, but my advice was immediately drowned out by other neighborhood "experts" who began to offer their own analyses of the medications. One woman lifted a bottle out of the pile, "Look. This one says 'Gastrosin,'" she said. "It must be a stomach medicine." "Can I take some to my sister?" another woman asked. "She's been having stomach problems." I tried to point out to her that the label actually read, "Ganostin" but she felt the distinction was unimportant and took the medicine anyway. When I expressed alarm about this unsupervised sharing of unknown pharmaceuticals to another neighbor later in the evening, she laughed sadly and said Cuba was the only country she had ever seen (she had lived abroad for many years) where people were so casual about informally exchanging

2. "Blat" can be loosely defined as a form of social networking power. The informal economy is also an informal society in that economic transactions are organized through kinship and other social networks. *Blat* refers to the resources one can command in this way.

medicines. “And it isn’t just medicines,” she said, shaking her head. “For some reason, people seem to think eyeglasses are interchangeable too. I try and tell them that each person has their own, but still every time my sister loses hers she tries to borrow mine.”

People who seek to consult informally with health professionals do so with the understanding that some sort of reciprocal exchange is necessary. Since these relations are based on kinship or reciprocity networks, however, money is not exchanged—an offer of cash in such a context would most likely be refused. Instead, this informal system seems to work on the principle of *sociolismo*³—relationships are based on mutual exchanges of favors that allow them to bypass or subvert the often irrational and tedious bureaucratic constraints of the official world.

These relationships seem to be most prevalent in areas that are characterized by shortages or scarce resources. If an individual needs a medical procedure, for instance, materials are often unavailable. Sometimes relatives from Miami are able to send the necessary supplies such as surgical thread, but other times a *socio* in the hospital or pharmacy is tapped to sequester the necessities. These dynamics are illustrated in the following narrative detailing a dental procedure. This narrative is notable not only for the fact that the entire medical procedure took place outside the formal system of health services, but also because all the equipment and materials were secured (meaning stolen) by a *socio* of the patient. My experience leads me to believe that this example is actually quite representative of the way many elective medical procedures are performed in Cuba today.

The Case of Pepe’s Tooth: When one of my wisdom teeth started coming in it hurt terribly, so I made an appointment with a friend of mine who’s a dentist to take it out. Well, when we first tried to schedule it, there weren’t enough materials available, so we had to put it off for a while, until he could hoard enough stuff [surgical materials]. First there weren’t any needles. Then no sterile water, then no

surgical thread. About three or four months went by before we could actually do the surgery. He had gradually stashed things away as he found them, and then, since he was a friend of mine, he had me come in on a Saturday when the clinic was closed to do it.

The only available anesthetic was local. They shot me up with Novocaine pretty good. I just closed my eyes for a while and didn’t feel my mouth at all. Then I made the mistake of trying to open my eyes and saw all this blood everywhere and all these awful instruments. Oh, it was horrible. Then the doctor got a hammer and chisel and started pounding away at my face. Hard! To keep my jaws aligned I had to bite down on this rubber thing on the left side—hard, for hours. At one point I started getting tired and loosened up on it and he yelled at me to keep biting down. If I slacked my jaw while he was pounding on the tooth he could easily lacerate my cheek or break my jaw or another tooth. So I had to keep biting down. Then the Novocaine started to wear off, and I started twitching in the chair. I think they had to shoot me up four different times in all. Anyway they went back to pounding away. Part of the problem was that the wisdom tooth was right up against the molar and there was hardly any room to work. The roots were incredibly deep too, and it left this huge canyon in my mouth.

There was only enough thread for four stitches. They tried to close it up as best they could, but as it started to heal, the skin swelled up too far and started covering the other tooth. Afterward I had this massive swelling in my face, all the way down my chest and neck. There was no infection, it was just from the trauma of the whole thing. And then they saw it was healing wrong and made me go back in, lie in the chair and then without any warning at all started abrading the wound to get it to bleed again, and to keep it from growing over and covering the next tooth. I screamed—it was so painful, but they kept right on. For weeks I could hardly open my mouth, or even eat anything my jaw was so sore.

3. *Sociolismo* is roughly the Cuban equivalent of *blat*. The word is itself satirical, implying that Cuban “socialism” is really “socio-lismo.” A *socio* is a friend who helps you subvert the bureaucracy and material shortages of the formal system.

Then as it started healing, little bits of bone were working themselves up through the socket. I'd spit them out. But then there was this one jagged little piece of bone poking out of the back part of my gum. It was just like a needle it was so sharp. I went in to the clinic, and they decided it must just be a loose splinter that had gotten stuck so they tried to pull it out. Well, it was still attached to my jawbone, but they practically ripped my jaw out of my head before they realized it and stopped yanking. So it stayed there and every time I ate or drank or talked too much it stuck me in the tongue, just like a needle. I got to where I'd put four or five pieces of chewing gum over it because I was tired of having my tongue pierced every time I tried to eat a sandwich. Then one night I got fed up and borrowed my wife's nail file, sterilized it good, and sat watching the Saturday night movie filing away that little bone to where it didn't hurt me so much any more. That pretty much took care of the problem, but I still have this huge socket from where the tooth was.

When *socios* are used to provide resources or services, the patient (and his or her family) is then obligated to repay the favor, ideally by allowing the doctor or health professional preferential treatment with respect to their workplace bureaucracies. If the patient works in a government ministry or office, the doctor may later appeal to him or her to resolve paperwork difficulties. Or, if the patient works in a brewery or factory, for instance, he or she may pilfer cases of beer or some other valuable commodity for the doctor or nurse who is a *socio*. This beer, in turn, may be sold by the doctor on the black market for cash, or traded to other *socios* who have access to other vital goods and services.

I was also able to observe how reciprocity networks are activated to secure consultations with more prestigious medical professionals. During the course of my fieldwork, I happened to meet one of Santiago's most highly regarded surgeons, who mentioned to me that he had been asked to undertake a medical mission abroad. Seeing an opportunity to get to know another health professional, and to make use of some of my spare time, I volunteered to give him some English lessons prior to his departure, and for

several weeks we met in the evenings for classes. Since I refused to take any money for this service, this meant that he was incurring an informal debt to me.

At the same time, I also incurred a significant debt to another friend, who devoted countless hours to repairing my bicycle one afternoon. My friend the bicycle repairman then broke his knee while playing soccer, and a few days afterwards his wife timidly approached me to ask if I might accompany her to the surgeon's house to ask if he would agree to (informally) provide a consultation for the broken knee.

I, of course, immediately agreed to this arrangement—essentially cashing in the favor the doctor owed to me in order to repay another favor I owed to someone else. I was pleased to be able to help, and curious to note how pervasive this informal exchange of favors appeared to be with respect to all dimensions of the health care system. In addition to consulting with the surgeon, for instance, Pablo also maintained regular contact with two other doctors (friends of his—one a sports medicine specialist and the other a generalist) who provided informal consulting services for his knee.

IMPLICATIONS FOR DISEASE CONTROL

The tendency of Cubans to seek medical care in the informal sector is fueled by both political and economic forces. The political surveillance and bureaucratic depersonalization of the state system create a natural incentive to informally "privatize" medical care. Clinical consultations that go on in this arena have a degree of privacy and humanity that is difficult to achieve in the formal sector. These informal clinics, however, also require material supplies: diagnostic machinery, bandages, surgical thread, disinfectants, etc. Health-seeking in the informal sector thus involves considerable parasitism on the formal sector.

These dynamics have a number of important implications for disease control. Informal economies are by definition unregulated, and medical encounters and transactions that take place in this sphere are invisible to state health planners. This invisibility makes accurate assessment of health trends very difficult—outbreaks of infectious disease can go un-

recognized, and treatment regimens are undertaken haphazardly, depending on availability of supplies. Furthermore, patients who obtain supplies and medications on the black market are at risk for a host of potential complications. In the case of medications, illicit pharmaceuticals could be outdated or inappropriate for certain patients. Self medication poses additional risks of inappropriate dosage or side effects.

The impoverishment of the formal health sector also means that hospitals and clinics are forced to work without a number of basic necessities such as disposable syringes, disinfectants and protective masks and gloves. These shortages greatly increase the likelihood of nosocomial diseases, or hospital-acquired infections. A similar pattern was manifest in the former Soviet Union where material shortages in the formal sector led to significant problems with HIV and tuberculosis among certain populations. One Soviet hospital reused glass syringes for vaccination and inadvertently transmitted HIV to over 250 children. In other clinics, supplies of antibiotics were so inconsistent that tuberculosis patients could never secure an adequate supply of medications to fully combat their disease. The result has been the evolution of multiple antibiotic resistant strains of tuberculosis, which are now epidemic in many Russian cities (Alibek, 1999; Garrett, 2000; Powell, 2000).

The paternalism of the formal health sector in socialist systems can also seriously impede effective control of chronic disease. William Cockerham has interpreted high chronic disease rates in the former Soviet Union as resulting from the inability of the Soviet system to address issues of lifestyle and behavior change. He specifically describes the paternalism of the Soviet system as discouraging a sense of individual responsibility with respect to health. "Health lifestyles in societies providing high levels of patronage and discouraging individual initiative in most aspects of daily life are not likely to feature a strong sense of individual responsibility" (Cockerham, 1999:79).

Cuba's medical system remains quite paternalistic, and the centralized state run economy offers people few choices with respect to lifestyle variables that influence health. Citizens are powerless to protest environmental pollution or occupational hazards, drink-

ing water is unclean and nutritious foods are hard to come by. Many people still smoke cigarettes, and are generally unfazed by periodic government antismoking campaigns. "Cigarettes and alcohol are one of the few pleasures the government allows us," one weary Santiago resident told me. "I'm not giving them up."

CONCLUSIONS: CUBA'S NEXT TRANSITION

The abrupt declines in health and life expectancy that occurred after Russia's post-socialist transition have been quite alarming. Epidemics of preventable diseases such as measles and diphtheria continue to plague Russia and other newly formed states, and overall mortality trends in these countries from both infectious and chronic diseases spiked sharply in the 1990s. Average life expectancy for Russian men decreased by at least ten years over the 1990s. Overall, Russia's national health profile has undergone a process of abrupt "third worldization" that many experts have been at a loss to fully explain (see Garrett, 2000; Cockerham, 1999; Field, 2000; Fituni, 1995).

In some cases, falsification of health statistics by the Soviet regime was to blame—health problems that had been officially denied for years suddenly became visible due to more accurate reporting. In other cases, political upheaval combined with rapid impoverishment of certain sectors of the population facilitated health declines. The wretched environmental legacy of the Soviet Union is also responsible for a good deal of the excess mortality from chronic diseases such as cancer.

How these dynamics will play out in a post-Castro Cuba remains to be seen. Cuba does have a solid health infrastructure in terms of the wide availability of medical services. Community medicine programs such as the Family Doctor have the potential to bring about significant health improvements at the grass roots level. As a number of scholars have shown, however, provision of health services does not correlate in a linear way with improvements in population health indicators (see McKeown, 1977; Harris 2004). Statistical health trends are more likely to be influenced by larger political, economic and environmental variables such as political stability, poverty, and the continuation of very basic state-level government prevention programs such as mosquito control

and water purification. If these areas of public health planning and surveillance become deficient in Cuba, individual doctors (despite their training and com-

munity focus) will be largely powerless to arrest the decline in health trends.

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