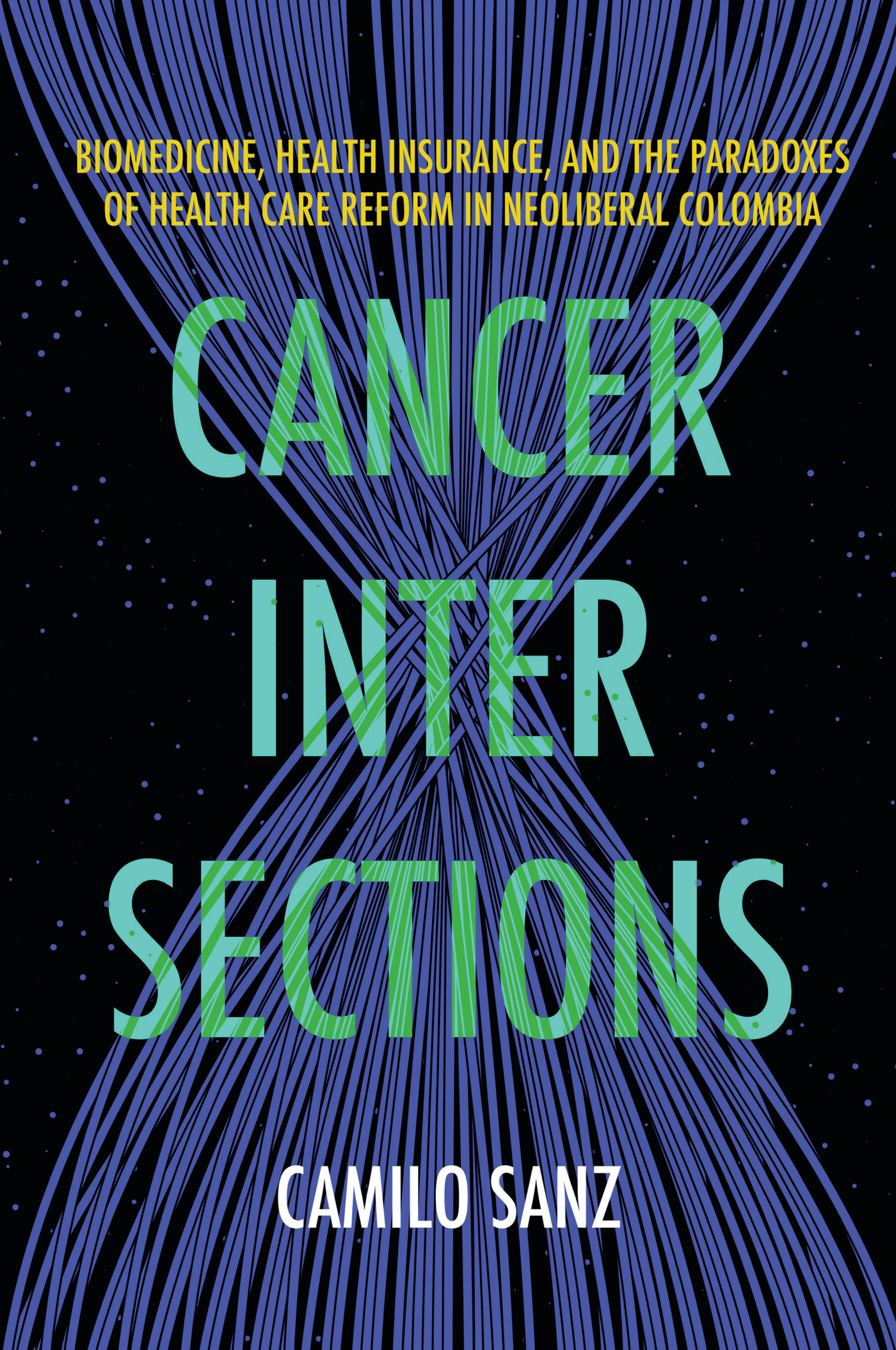

BIOMEDICINE, HEALTH INSURANCE, AND THE PARADOXES OF HEALTH CARE REFORM IN NEOLIBERAL COLOMBIA

CANCER INTERSECTIONS

CAMILO SANZ

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Camilo Sanz

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To Jhoja: my wife and best friend.

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Introduction

In 2011 I returned home to the city of Cali, in southwestern Colombia, to begin ethnographic fieldwork on biomedical cancer care. When I arrived, I found myself in the middle of a series of popular uprisings, policy reforms, and legislative actions aimed at counteracting the inequities exacerbated by the 1993 neoliberal transformation of the national health care system. This new for-profit structure had dismantled the welfare state and created a market of insurance and health care providers. One of its main goals was to guarantee a model of universal medical care coverage, regardless of patients' socioeconomic status. Many of my interlocutors, however—especially at resource-scarce public hospitals—were frustrated with the failed promises of the 1993 reform and appalled by the destruction of the medical services it sought to guarantee in the first place.[1]

Despite the atmosphere of unrest and enervation I encountered, these same interlocutors referred to the crisis as a unique opportunity for moving beyond the for-profit logic and toward social justice and health care equality. Their hope for structural transformation had been fueled in part by the Constitutional Court's declaration of health as a fundamental right in 2008, which would later unleash landmark legislation to further protect and regulate this right.[2] Harnessing the ripple effects of the court's declaration and its potential for guaranteeing health care to all Colombians, President Juan Manuel Santos (2010–18), a savvy establishment politician and member of a traditional family from Bogotá, sought to enact health policy changes aimed at reducing inequities and enforcing stricter financial vigilance of the health care market.[3]

Nearly thirty years after the neoliberalization of the health care system and numerous government efforts to amend its failures, the initial promise of universal

MAP 1. Colombia and surrounding regions. The city of Cali (1) and the Valle del Cauca department (2) are highlighted. Credit: Shadowxfox, https://commons.wikimedia.org/wiki/File:Colombia_Valle_del_Cauca_loc_map.svg.

health insurance enrollment has finally been achieved.[4] In addition to such an important milestone, Colombia became one of the countries in the region with the lowest out-of-pocket medical expenses. My interlocutors' hope about the materialization of radical changes appeared to be unfolding, in a way.

"Health care for all," however, never translated into prompt and equitable access for all Colombians (Marmot 2013). When patients suffer from high-cost conditions such as cancer, the time it takes to access standard oncology treatments (surgery, radiotherapy, and chemotherapy) is correlated to their socioeconomic status and the type of health insurance they qualify for. As a result, cancer may get transformed into a chronic, livable condition for some patients while life is merely promised to others.

During my ethnographic research in Cali, I was puzzled by the contrasting biomedical practices, which led me to one of the questions that inform this book: How do socioeconomic status and health insurance enrollment shape oncological practice, and what are its consequences? Practicing medicine, after all—like any other scientific endeavor—involves different tools, processes, and participants and their articulation across spaces (Mol 2002). Hence I began paying attention to cancer treatments as they were being practiced across hospitals, health insurance offices, and patients' homes. One of the implications of this approach, echoing Isabelle Stengers's *Ecology of Practices* (2005b), is that no practice can be understood apart from its surroundings.[5] Only by locating a practice within its milieu—studying how it arises from and is embroiled in its circumstances[6]—can we be positioned to understand it (Marenko 2021).

Coinciding with Stengers's work but going beyond it, my ethnography studies the borders of practices where a series of divergent interests *intersect*. My emphasis on *intersections* allows me to point at articulations between practices, which have a common interest like curing or treating cancer but which must juggle other interests as requisites—for instance, the health insurance sector's financial vigilance and the hospital's need to sell more services. *Cancer Intersections*, therefore, is an attempt to study health insurance and biomedical practices and their entanglements with a disease of voracious growth in a market of unlimited growth. It discusses the complex, multiple, conflicted, and even paradoxical efforts to treat cancer in the aftermath of the 1993 neoliberal transformation.

My first few months of fieldwork in Cali transpired at Fundación Valle del Lili, a private nonprofit hospital that was built in the 1990s. Funded by some of the most traditional families and businesses in the region, Valle del Lili's core mission is to provide high-complexity medical services to all individuals living in Cali (and the rest of Valle del Cauca department), who until that time had to travel to other parts of the country to receive specialized medical treatments. Soon after opening the doors of its main facility in south Cali, this hospital became one of the top third-level medical settings in the country and in Latin America.[7] Over the years it has continued to grow and expand into less affluent neighborhoods beyond its original location nestled among high-end malls, country clubs, and elite university campuses.[8] Recently, Valle del Lili announced that its oncology department was ranked first in the nation in terms of its state-of-the-art technology, internationally renowned medical practitioners, treatment outcomes, and active research agenda.

Crucially, while both public and private hospitals are encouraged to sign contractual agreements with all health insurance companies in the market, not all

FIGURE 1. One of the entrances to Valle del Lili hospital. Courtesy of Maria Cristina Piñeros.

insurance companies are created equal. The neoliberal transformation of 1993 created a "portfolio" of insurers that cater to different kinds of patients and their differing socioeconomic status. The result is that the timing of patients' access to medical services comes down to their insurance and how competitive their insurance companies are in the health care market, their financial liquidity, the number of enrollees (potential hospital clients), and their proven record of timely payments to medical providers.

Before long I was granted access to a public hospital, Hospital Universitario del Valle (HUV), the Universidad del Valle's flagship hospital. HUV was funded in 1936. It is one of the few third-level medical institutions in Colombia's southwest.[9] Its patients, who are typically enrolled in health insurance for the poor or the unemployed, have typically sought specialized medical interventions such as oncological treatments. Despite its long history and crucial importance for the health of millions of Colombians, it was on the verge of bankruptcy during my fieldwork. This is a common pattern among public hospitals in the country that were transformed into self-reliant businesses (Abadía-Barrero 2022).

FIGURE 2. Main entrance to Hospital Universitario del Valle. Credit: Remux, https://commons.wikimedia.org/w/index.php?curid=28472191.

Because my first encounters with cancer treatment in Colombia had taken place at Valle del Lili, with its cutting-edge oncology services and integral palliative care approach, when I arrived at HUV I was struck by the ordinariness of untreated pain and the ubiquity of metastatic cancers among patients. The contrasts in medico-insurance practices and cancer prognoses across these hospitals were puzzling and would become the prime motivators for writing this book. By moving across these worlds of medicine, I explore how social class determines timely access to oncology treatments (often high-cost) and how even in resource-rich settings patients suffer as a result of market imperatives that shape how cancer treatments ordinarily unfold.

A clarification: Even though public and private hospitals in the country must provide care for all Colombians, regardless of their ability to pay, not all hospitals are willing to sign contractual agreements with every health insurance company in the market, especially those that have defaulted on payments or are on the verge of bankruptcy (usually companies that offer insurance to the poor or unemployed population). In the end, the risk associated with partnering with these insurance companies is typically taken on by public hospitals, most of which, like HUV, have pressing financial needs too. Hence the common interest in treating or curing cancer must first satisfy hospitals' corporate financial requirement to increase sale of medical services, health insurance companies' need to limit treatment, and physicians' ethics concerning curing or slowing the pace of cancers.

. . .

At HUV I met one of my closest interlocutors, whom I call Dr. Masa. He is a senior oncologist. A former university professor, he is skillful at translating medical knowledge for nonexperts like me, a cultural anthropologist without medical training. Anticipating my bewilderment during my first visit to HUV's oncology wards, Dr. Masa said nonchalantly, "Young man, cancer care in Colombia is complicated. Poor patients have the right to access medical services, but at the same time they don't. Es como tener madre—pero muerta. ¿Si me hago entender? [It is like having a mother—but dead. Am I making sense?]."

"Tener madre, pero muerta" (to have a mother—but dead) is a popular expression in Colombian Spanish used to describe the coexistence of seemingly incompatible states of being—a possible impossibility (Derrida 2007). How can someone—like a mother—*be* and *not be* at the same time? This phrase describes something that does exist, at least nominally, but because it is dysfunctional, it has been interrupted or allowed to die. Dr. Masa used this phrase to illustrate the systematic obstacles to accessing cancer treatments in a country where health care is universal and a fundamental right but also a commodity "understood as an individual responsibility to be purchased in a 'regulated' insurance market" (Abadía-Barrero 2022, 103).

I took seriously Dr. Masa's popular sayings. His explanations informed my thinking and shaped my discussion on biomedical cancer care and its paradoxes. But his social skills and rapport with patients were far more pivotal. Throughout my time at HUV, Dr. Masa introduced me to many of his patients and their family members, with whom I built long-lasting relationships. Thanks to him, patients felt comfortable with my presence and were willing to invite me into their lives. Building on my encounter with one of them, below I flesh out Dr. Masa's words and discuss how the policies designed to fight inequities are, in fact, exacerbating them.

Jairo has stage IV prostate cancer with metastasis to his liver,[10] which means that his disease has moved beyond its original location and become incurable. For several months, Dr. Masa sought to treat his cancer with a series of radiotherapy and cisplatin-based chemotherapy protocols to slow the growth of his tumors, to no avail.[11] Jairo spent nearly two months waiting for insurance approvals and additional time trying to schedule appointments at HUV for his intravenous (IV) infusions.

After several attempts to get in touch with someone at the oncology wards, a nurse finally picked up the phone and confirmed that his chemotherapy infusion had been scheduled the following morning. Yet Jairo was frustrated and protested, "¡Ya para que!" (roughly translated as "Now for what!"). Because his tumors kept growing as a result of systematic delays in the provision of prescribed chemotherapy, his chances for living longer with the disease were dramatically reduced.

"So, you know, I am waking up every morning with extreme fatigue and swollen legs," he explained. "But the pain, this pain [points to his groin] is unbearable. And it gets worse when I get out of bed, roll up my catheter, and walk to the toilet. That's when things go out of control. [Long pause.] That's when I wonder whether my current situation would have been different had I gotten all my treatments on time."

With a mix of irony and mild irritation, he mumbled, "I told the nurse *gracias por nada señorita* [thank you for nothing, miss], that I sincerely appreciated the time she had taken to notify me ahead of time." He grabbed my arm and pulled me forward. Jairo wanted to make sure he was getting my undivided attention. Looking directly into my eyes, he went on to say, "Can you believe it? I was notified about my appointment just the day before I am supposed to show up at the hospital. Had I not dialed the phone like a madman, I would never have come to know about my appointment."

Jairo went silent for a few seconds before continuing his account.

"So, I couldn't help it and hung up the phone. What else was I supposed to do?," he mumbled with frustration. "A number of times I have woken up early in the morning and taken buses to the infusion room just to be sent back home because the hospital union is picketing. Can you believe it? So, in addition to my cancer, the slow queues, the waiting, and the paperwork, now it turns out we must also check in advance the union's protest schedules and plan accordingly."

To help him get his chemotherapy infusion on time, I had a rather simple plan.[12] I would take a taxi at dawn, pick him up at his home in the Ciudad Córdoba neighborhood,[13] and head to HUV's oncology wards. A taxi would save him time, and Jairo would be more comfortable in a car than in a packed bus that follows no set schedule. To play it safe, I had already checked with health care practitioners and ruled out any possible protest that day.

Although he was visibly fatigued, dealing with untreated pain and swollen legs, and frustrated by the last-minute notice about his appointment, he was willing to do whatever it took to access the medical services he was prescribed. Jairo mused in a combative tone: "I might have an advanced cancer, but it does not mean I will just sit down and cross my arms. I will get them [treatments], you will see. Slowly but surely [*lento pero seguro*] I will keep fighting; slowly but surely I will get all the medical services I am entitled to." Jairo was not planning to let go, regardless of the burdensome health insurance obstacles and disease prognosis. His contentious words took me by surprise after learning that his metastatic cancer had turned more aggressive over the past few weeks—and will ultimately be the cause of his death.[14]

The following morning, he sat in the taxi's backseat by himself. Hoping to ease his pain, he leaned against a door and fully extended his swollen legs on the seat. On our way to the hospital, he shared stories about his unshakable resolve to keep hopping on buses and trying to arrive on time for his chemo appointments. As someone who has—luckily—never been a cancer patient, I can hardly imagine how he manages to endure long bus rides while dealing with a metastatic disease and spend hours in waiting rooms just to be sent back home after learning that health care practitioners are picketing to demand the immediate payment of their salaries.

Halfway to HUV we hit heavy traffic. The early morning momentum had been replaced by a soporific state—at least for me. I began nodding in the passenger seat, but when I suddenly looked through the rearview mirror I saw Jairo crouching on the backseat. His pain had returned with a vengeance, and I wasn't sure how to help him. I asked the taxi driver to speed up and find an alternative route to HUV or drop us off at a different hospital. But we were stuck in traffic and would remain at the same intersection for nearly half an hour. When the taxi finally dropped us off at HUV's main entrance, I rushed inside the building in search of a wheelchair for Jairo, but there were none available in the designated area—just a pile of scrap furniture and a metallic bin overflowing with trash. As is often the case for so many public hospitals in Colombia, HUV was going through one of its worst financial crises. At the time of my research its aging infrastructure was overdue for critical renovations, its machines were often broken, and stretchers and wheelchairs were nowhere to be found.

Jairo and I arrived an hour late at the oncology wards. I announced him at the front desk and requested a painkiller to ease the pain. A nurse handed me the usual hospital paperwork and asked that Jairo sign it and wait. "Because his appointment time has passed, I can't guarantee he will get seen today. But you are welcome to stick around and see whether a spot becomes available for him," she mused.

Her words left us wondering if we would be stuck in the waiting room until late afternoon, just to be asked to come back at a later date. Hoping to get a better idea about our odds, I stepped closer to the front desk and asked with slight trepidation, "I am sorry, but when will that be?" Visibly irritated, the nurse looked at me and said, "Look, sir, *se hace lo que se puede* [we do what we can]. Can't you see the high volume of patients we have today? Besides, you guys are late. Please have a seat."

Indeed. There was not much Jairo or I could do at this moment, except, perhaps, get a drug to ease his pain.

"What about his pain?" I gently insisted, hoping she had not forgotten my plea.

"Yes, yes, whenever he gets called," the nurse said while nodding toward the chemotherapy infusion room.

Given the prospect of a long day at HUV, Jairo would need to get as comfortable as possible. Each passing minute had the potential to make his symptoms unbearable. Jairo's immediate priority was to raise his swollen legs and keep them up for as long as possible. The challenge, however, was finding a spot to lie down in a packed waiting room.

I walked around the facility and managed to gather a few vacant chairs. Jairo dragged them against a wall—in a straight line. He laid down and tried several positions. He slightly bent his back to the sides, placed padded support under his head, and flexed his legs to relieve his back pain. In the meantime, I paid a quick visit to the hospital pharmacy. Hoping to find a strong pain medication, I instead settled on a box of ibuprofen. Getting stronger (and government-controlled) pain medications like hydromorphone, an opioid, requires providing pharmacists with an official prescription—which Jairo had lost.

Jairo's frustrating attempts at getting his chemotherapy infusions were in part shaped by the neoliberal Ley 100. This is the law that transformed the model of health care delivery in 1993 from social insurance and publicly financed health care institutions to regulated competition in the administration of universal health insurance. According to the new law, people were required to establish contracts with health insurance companies known as EPSs (*empresas promotoras de salud*, or health promotion companies). These EPSs are the public, private, or mixed for-profit entities that play a role as intermediaries between the government,[15] health care providers, and patients.

This model of universal health insurance is based on financial solidarity between rich and poor populations—whereby the wealthy spend more than the low-income populations.[16] As I explain elsewhere (Sanz 2017), it is structured on two regimens of EPS enrollment: a contributive regime (CR) for individuals whose incomes are twice the minimum wage and a subsidized regime (SR) that covers low-income and unemployed Colombians with funds transferred from the CR and the government.[17] Ley 100 also created a market for private prepaid insurance, known as *medicina prepagada*, which provides coverage for the highest socioeconomic strata beyond that offered by EPSs.[18] This expansion of coverage was revolutionary in and of itself and transformed Colombia into one of the countries with the lowest out-of-pocket expenses in the (so-called) developing world (Castaño 2023).

This insurance stratification model, however, came to be superimposed on the preexisting class divisions that have plagued Colombia since colonial times and that have transformed the country into one of the most unequal in the region. As a result, this health insurance model shapes the type of medical services patients get and dictates the timing for accessing treatments, especially among those individuals considered "high-cost." In a market where insurers and providers compete for clients, only those who offer the "best" business potential get to sign contractual agreements with highly coveted providers, like Valle del Lili. For insurance companies, the potential for growth revolves around being able to offer hospitals the highest (more competitive) rates in exchange for the medical services they provide to their enrollees and to guarantee timely payments. For hospitals, it means offering medical services with the highest quality at the lowest rates compared to their direct competitors. The result is highly unequal access to high-cost medical services in a health care system in which the common goal is to treat or cure cancer but which must pursue financial interests as requisites.

Unlike other countries in the region, in Colombia the issue is not so much the lack of resources or the improvisation of medical practices but the waiting required to access treatments that all citizens are entitled to by law.[19] Here I build on Javier Auyero's now-classic work in Argentina, *Patients of the State* (2012), which responds to Pierre Bourdieu's (2000) call for analyzing the waiting experiences of poor people. As a biopolitical technique through which bodies are governed (Foucault 2008), Bourdieu explained, waiting is a way of "turning down" without "turning off," of keeping patients motivated without driving them to despair.[20] As such, deferring, delaying, and raising false hopes are practices through which low-income individuals are transformed into responsible and disciplined citizens. In Auyero's ethnography of a social service office in Buenos Aires, he describes how low-income populations must patiently comply with seemingly arbitrary and confusing state requirements to access welfare services. He shows how waiting is stratified. Waiting time is inversely correlated with individuals' socioeconomic status.

Equivalent to the experience of poor individuals in Buenos Aires, the amount of waiting endured by cancer patients in Colombia is correlated with their socioeconomic conditions and health insurance regimes.[21] Crucially, waiting or wasting time, I argue, is not only a biopolitical technique (Foucault 2008), but a practice required to negotiate the health care system's burdensome bureaucracy and financial costs (Abadía and Oviedo 2009; Hull 2012).

Spanning a total of seven years of ethnographic fieldwork in Cali, with the most intensive stretch in 2011–13, *Cancer Intersections* discusses how the market decides whose cancers are worth transforming into chronic conditions and whose bodies are *already dead*. The literary theorist Eric Cazdyn (2012, 163), who coined the term "already dead," describes it as a "state when one has been killed but has yet to die, or when one has died but has yet to be killed." In the context of Colombian cancer care, the *already dead* refers to the killing of high-cost/low-income patients who may not die immediately. In this double future, a conditional past does not exist. *El hubiera no existe* (*Hadn't* does not exist) simply because individuals' future with a deadly cancer has already unfolded into their present.

In the case of Jairo, there is little he could have done differently in the past—getting screened, for instance—to increase the likelihood of being cured or living longer with the disease. After all, primary health care is fragmented in Colombia, and barriers to medical services persist, especially in rural and remote areas (OECD 2015). In addition, these medical services have revolved around temporary fixes that fail to account for the role played by structural determinants of health (Mull 1990; Basilico et al. 2013; Abadía-Barrero and Bugbee 2019). And there is not much poor patients can do in the present, like accessing traditional cancer treatment modalities to cure or slow the pace of growing tumors. Even when low-income patients get access to their anti-cancer treatments, it is often too late; their diseases are too advanced, often metastatic.[22] "¡Ya para que!" Jairo had grudgingly told the nurse. "¡Ya para que!" if his cancer would not respond to the cisplatin regime originally prescribed by Dr. Masa.

My ethnography highlights two major reasons that cancer treatments often produce more exhaustion and pain for Colombians. The first is the delays by health insurance companies to maximize their profit (see chapter 1). The second is the tendency of biomedical practice (especially under capitalism) to encourage aggressive, early, and costly interventions to treat cancer (even when the diagnosis is unclear; see chapter 3) and extend life (see chapter 5). As the anthropologist Amy Cooper urged me to bear in mind,[23] this latter dynamic is not only a product of neoliberalism or even capitalism; it is a feature of high-tech biomedicine itself, which happens to meld quite well with market-based logics. People with financial resources are only facing the latter dynamic, while low-income individuals face the former dynamic and to some extent also experience the latter dynamic when they can freely access biomedicine via writs known in Spanish as *tutelas*.[24] Paradoxically, as shown in chapters 2 and 4, the tutela has played a role in reproducing the same inequalities it was created to counteract. Hence my decision to end this book with a reflection on palliative care and euthanasia (assisted-dying) as emancipatory possibilities. These two medical practices have the potential for developing new relationships with decay and death, as well as for counteracting the tensions between a disease of uncontrolled growth and an economy of unlimited growth.

JUSTICE BEYOND CURE

The situation of many patients at HUV was dire and desperate. But there was something else that struck me. Despite patients' frustrating encounters with the medico-insurance bureaucracy—their uncontrolled symptoms and metastatic cancers—most of them were usually hopeful and confident about the medical services they were entitled to by law. In Bourdieu's terms, they had been turned down but not turned off.

Unlike countries where citizens still passively accept the impossibility of accessing high-cost treatments,[25] in Colombia the Constitutional Court elevated health to a fundamental right in 2008, whereas before it was just considered a service.[26] Through this proclamation, the court ordered the government to address the many structural malfunctions that were preventing patients from accessing the medical services they needed. In 2015, Ley Estatutaria en Salud (LES) was promulgated; it established the mechanisms for the protection of the right to health and sought to improve the quality of and access to medical services (Ramirez et al. 2016).

Despite the profound implications unleashed by this landmark legislation, health insurance companies continue to delay access to medical services for low-income patients, especially those who suffer from high-cost diseases such as cancer.

Ironically, it is often when the patient's cancer has metastasized that the state intervenes to "save" the patient's life through tutelas, writs created in 1991 to impart neoliberal justice and protect fundamental rights of all Colombians, such as health and life (Ambito Jurídico 2012; Abadía-Barrero 2015b; Arrieta-Gómez 2018).[27] While filing tutelas has become routine for many patients, these writs are not exclusive to Colombia. Their increasingly central role indicates the widespread problems in the functioning of health care systems in many other places in the Global South (Biehl et al. 2012; Biehl and Petryna 2013; Graham 2016; Tichenor 2017; Abadía-Barrero and Bugbee 2019; Iriart and Gibbon 2023).

Over the years, tutelas have inundated the Colombian judicial system because they are easy to file and judges tend to approve them in record time (within ten business days). In 2019, for instance, every thirty-four seconds a patient petitioned the judiciary to issue a writ affirming their right to health care (Defensoría del Pueblo 2019). Most of these tutelas point at EPSs as the main target of complaints (Abadía-Barrero 2015b, 2022), largely because they tend to defer access to care, even medical services included in the national formulary, the Plan Obligatorio de Salud (POS) (Defensoría del Pueblo 2013, 2018).[28]

Crucially, patients like Jairo are keenly aware of their rights and how to protect them via tutelas (see Gaviria 2020).[29] "Los entutelo a todos [I will sue them all]," my friend protested while raising his left arm and making a fist with his hand. Jairo was willing to keep going back and forth to his health insurance office, HUV, and pharmacies. "I might be a poor patient, but I am not *pendejo* [a fool]. The government will have to *poner plata* [chip in], especially now that my cancer is incurable," he said, while rubbing his index finger and thumb together—a gesture that represents money in Colombia and elsewhere. "I would rather be dead than a fool," Jairo concluded. As an *already dead*, Jairo has learned to hold on to the possibility of making the government pay, even if that payment will not cure him (and may not provide quality of life either).

Jurisprudence in Colombia has sought to guarantee access to medical services *but not only*.[30] Patients like Jairo often conclude that letting their bodies deteriorate beyond the point of cure may actually provide an edge. Doing so, they reason, could help them prove before a judge that their fundamental rights, such as health and life, have been violated. Under these conditions, the tutela would allow patients to fully engage with the system from the perspective of having a life already lost (Cazdyn 2012). These individuals are caught between the promise of health care and its simultaneous impossibility, that is, knowing one is a subject of fundamental rights that are often protected when they have been violated.

As a result, when patients decide to "waste time" on their quest to access medical services, their decision may not respond to their desire to get cured but rather to the possibility of becoming visible before the state and have it "pay" for the treatments they have missed—regardless of prognoses and outcomes.[31] *Cancer Intersections* discusses how universal health care is intimately connected to the delay in the provision of cancer treatments and the reproduction of historical inequalities. The promise of universal health care, after all, as the Indian public health expert Imrana Qadeer (2013, 149) argues, has the potential to become the "Trojan horse of neoliberal strategies." In neoliberal Colombia, therefore, tutelas may set perverse financial incentives that encourage patients to wait and deteriorate while EPSs continue delaying the provision of "high-cost" treatments and maximizing their own profit.

NEOLIBERALISM AND ITS PARADOXES

In Latin America, neoliberalism has been typically understood as a set of economic practices—known as structural adjustment policies—that were imposed from above by international financial institutions, corporations, and governments. From privatization and financial deregulation to reductions in social protections, the continent has been experiencing the effects unleashed by these neoliberal reforms implemented during the 1980s and 1990s (see Martinez 2018). From that point forward, an expanding collection of scholarly works has sought to analyze how these policies propelled from above were unsustainable and unable to fulfill the assured promises (Harvey 2005; Homedes and Ugalde 2005b; Hartmann 2016).

Echoing social scientists who have studied neoliberal practices in Latin America (Han 2012; Gago 2017; Abadía-Barrero 2022), this book does not seek to portray neoliberalism as a historical moment or set of homogeneous arrangements among markets and the state or as the newest iteration of laissez-faire capitalism (see Povinelli 2012). As a category of analysis, the value of neoliberalism is often limited, hence the importance of not rushing to conclude that certain policies and practices may be labeled neoliberal (Mains 2012). Its value, after all, "depends on its landings and connections with concrete situations" (Gago 2017, 160).

In Ethiopia, for instance, instead of echoing what other scholars have described as the thinning of the neoliberal state (Harvey 2005; Ferguson 2006), Dan Mains (2012, 5) has observed the "state reemerging and playing a central role in generating linear development." In that country the privatization of infrastructural development does not fit easily with this common conception of neoliberalism. People in Ethiopia, Mains notes, have often assumed that the state has "the power to create jobs, transform the city, and improve life" (5).

Veronica Gago's (2017) work in Argentina has described how neoliberalism gets restructured into a new dynamic that overflows its classical definitions. In her ethnography of La Salada market in Buenos Aires, Gago refers to neoliberalism as a set of practices characterized by a new type of rationality that can hardly come exclusively "from above." Gago's thesis is that "neoliberalism survives as a set of practices that are manifested from above, as a renewal of the dispossessive form and, from below, as a rationality that negotiates profits in this context of dispossession" (5).[32] By neoliberalism "from below," she is referring to a set of conditions that are materialized beyond the will of the government. The encounter between neoliberal dynamics from above and from below gets simultaneously negotiated, Gago further explains.

Informed by these ethnographic findings, *Cancer Intersections* pays attention to the landings of neoliberalism in the context of biomedical cancer care in Colombia and explores its paradoxes. Neoliberalism's nature, I suggest, is precisely defined by an articulation of apparently irreconcilable differences in such a way that it no longer requires to rectify what had contradicted it.[33] This book discusses how neoliberalism does not emerge from dichotomic relations between independent parts—above and below, state and market—but through a mutual becoming.[34] Following Deleuze and Guattari's (1987) famous account of the wasp and the orchid, elements that are seemingly different need each other because without the other neither would be able to achieve its goals. For instance, to grow and become self-propelled entities, malignant cells must build on regular cellular biochemistry and mimic their behavior to avoid being detected by our immune system; to protect the right to health, low-income patients must first endure its violation; to create profit, insurance businesses rely on the state's disbursements of funds, a form of subsidized growth.[35] Practices that were intended to stay separate may actually come together. When studied at their borders, where they intersect and diverge (Stengers 2005b), these practices are often described as paradoxical.

The word *paradox* refers to a self-contradictory statement or a statement that goes against one's expectation. *Para-* means "alongside," "beyond," and "contrary to." *Para*military groups, for instance—like the ones that blossomed in Colombia during the 1990s and early 2000s[36]—are groups of soldiers (assassins) that resemble and often fight *alongside* the official military forces of the state (Valencia 2007). They are the same but different; their actions seem to emerge from outside the state, but they do not. In the field of oncology, physicians are familiar with *para*gangliomas, a type of neuroendocrine tumor that forms *near* certain blood vessels and nerves outside of the adrenal glands; in the literary world, *para*phrasing means to reword something written or spoken in such a way that the new wording is still close to the original's meaning. From military organizations to physiological structures and ways of communicating, things and practices unfold alongside their seeming opposites.

Doxa or *doxon*, on the other hand, comes from the Greek word *dokein*, meaning "popular opinion," "belief," or "to seem." In his *Outline of a Theory of Practice* (1977), Bourdieu used the term *doxa* to highlight a society's taken-for-granted, unquestioned truths. It encompasses what belongs to the domain of the possible, that which "goes without saying because it comes without saying" (167).

Together, *para* + *doxa* make up a word that refers to something that goes alongside or against taken-for-granted truths or claims. As such, a *paradox* is a statement containing seemingly opposite ideas that make it seem impossible or unlikely, although it is probably true.[37] It allows for impossible simultaneity or, as Dr. Masa would have it, "to have a mother—but dead."[38] That is, medical and insurance practices may seem to buttress the right to health and universal access to health care services while at the same time render these unplausible. While Ley 100, for instance, guarantees access to medical services, it kills "low-income/high-cost" cancer patients in the process—even though it is presented as their salvation.

By tracing the paradoxical relations through which actors and their practices come to be intertwined, *Cancer Intersections* sets out to provide an analysis of biomedical cancer in the aftermath of the 1993 neoliberal reform. The chapters in this book analyze what happens on the ground when a disease of *self-devouring growth* meets an economy of unlimited growth (Livingston 2019).[39]

A PATHOLOGY OF EXCESS

"Cancer" is an umbrella term for thousands of diseases that have in common uncontrolled cellular growth and excess (Livingston 2012). It is not a foreign invader—a virus or a bacteria—or a dysfunction of our organs.[40] The life of this disease has been described by the oncologist Siddhartha Mukherjee (2012) as a recapitulation of the life of the body, that is, a mirror of our own life. Following this author, cancer starts when our cells undergo mutations and lose "key safeguards" that usually keep their growth in check. As a result, this disease acquires the potential for transforming tissues into its source of nutrients—hence its self-devouring growth (Livingston 2019). Over time, cellular descendants keep acquiring new mutations. While some of these may not have immediate biochemical implications, others will render cells far more efficient at multiplying and tricking the immune system.

Killing a cancerous cell in isolation is a rather easy task. Nearly any chemical poison can get rid of malignant cells almost immediately, paraphrasing Mukherjee (2012). However, when these cells grow inside living bodies, killing them may have devastating collateral effects for patients, especially when they have spread beyond their initial location and into other organs or tissues.

In her ethnography of an oncology ward in Botswana, Livingston (2012) describes cancer as a disease of "temporal urgency." The sooner these versions of ourselves are excised by surgery or killed by chemotherapy and/or radiotherapy, according to standard medical knowledge, the better the chances we have for getting cured or living longer. Precancerous lesions should ideally be identified before they become malignant or diagnosed at stage I when the disease is still self-contained, or in situ.[41] Following this logic for acting quickly and early, then, it would make sense to periodically assess our risk levels for developing certain forms of cancer—in terms of environmental, genetic, or lifestyle factors—and undergo screenings and checkups (see Dumit 2012).

Therefore, it is understandable that cancer patients and their treating physicians would often make the choice of pursuing aggressive treatments to play it safe, even if the benefits are unclear. Yet cancer is an unpredictable disease. Just as there are highly aggressive and lethal malignancies that take root in vital organs such as the pancreas, there are other indolent incarnations commonly associated with the prostate or breast that may take years or decades to turn into a life-threatening condition. Despite the crucial advances in our understanding of this disease, physicians are debating how to better define cancer (Esserman and Eggener 2023), especially some of its early manifestations that may never grow and metastasize.

My ethnographic observations were largely focused on IV chemotherapy, an umbrella term for a wide variety of medications that include cytotoxic (cell-killing) agents—known to be occupationally hazardous.[42] Elsewhere I have discussed that its effects are most powerful—and less toxic—when taken during fleeting *windows of opportunity* (Sanz 2017). In each of these windows, cells undergo specific morphological and biochemical transformations that make them vulnerable to certain chemicals, dosage quantities, and frequencies of administration. No two treatments in the life of cancer can be equally matched to the same chemotherapy regime—just as the same shoe size won't fit the rapidly growing toddler's feet for too long. Thus physicians often must conduct screenings and run tests on patients to recalibrate chemo protocols and/or dosages. In other words, there needs to be a permanent reassessment of tumors to get an edge on their growth and mutations (see chapter 1).

For low-income patients in Colombia who receive care at resource-scarce hospitals like HUV, however, this periodic reassessment of tumor's biochemical behavior was a rare event. During my longest stretch of fieldwork, nearly 70 percent of patients in Colombia who were diagnosed with this disease had metastases of some sort (Ministerio de Salud y Protección Social 2012). Other anthropologists working in the Global South have demonstrated that cancer is usually hosted in bodies that cannot keep up with its uncontrolled growth (Livingston 2012; Martínez 2018; Banerjee 2020). The entanglement of class inequities and fragmented primary care makes it difficult for patients like Jairo to get screenings and checkups that may catch cancers in their early stages, increasing chances of getting cured or living longer. Under these conditions, exacerbated by ensuing exhaustion and chronic stress,[43] even indolent cancers may become death sentences.

TOGETHER BUT NOT JUMBLED (*JUNTOS PERO NO REVUELTOS*)

This book discusses how cancer is rendered visible and (un)treatable at intersections of health care that emerge alongside each other—sometimes inside the same hospital or in the same neighborhood. Even though patients who inhabit these intersections may often run into each other at the same medical consultations and waiting rooms, their accounts of health care experiences are often difficult to reconcile.

To illustrate the ordinariness of these differences, let me introduce Felix, an Astra-Zeneca pharmaceutical representative who has been visiting the oncology wards at HUV for more than six years. He spends most of his time following doctors, swinging by their offices, and reminding them about Astra-Zeneca's oncology products. The high volume of cancer patients at HUV makes this hospital a high priority for him. Its location too is strategic in terms of his sales goals; HUV is walking distance from Imbanaco hospital, a top-notch private institution that often represents a coveted high-end market for the pharma industry. Felix can easily walk back and forth between these two medical settings. During a regular week, he often meets physicians for lunch at Imbanaco and later grabs coffee at HUV.

When I was telling Felix about my research on health care inequities and the role played by EPSs, he immediately felt compelled to correct my approach.

"You need to be careful," Felix said. "Don't focus on the negative things." Immediately, he went on to clarify his words, sort of: "What I am saying is that you need to avoid reaching the simplistic conclusion that cancer patients die because EPSs delay their access to treatments in order to increase their profits. That is not necessarily true. Not all EPSs are that evil. Some of them have been providing excellent service to their patients for a number of years. In fact, EPSs allow the health care system to be sustainable; they oversee expenses in health care and manage budget constraints. In so doing, these businesses guarantee that public funds are not misused. Otherwise, anyone could end up getting sumptuous treatments or aesthetic procedures."

Throughout my fieldwork, while observing in hospitals or following patients at EPSs, I would recall Felix's words. His advice made me more aware of how my own assumptions and beliefs shape the analysis presented in this book. Taking his words seriously, I have tried to avoid pointing at EPSs as the poster child of the health care crisis.[44] There are, in fact, a variety of medico-insurance practices and conflicting interests that shape how high-cost diseases are treated (or not) in Colombia. My intention is not to present an exposé of the inner workings of health insurance. In any given system—following the Colombian health policy expert Ramon Castaño (2023)—whoever assumes the role of payer or financial overseer will often be seen as mainly responsible for violating the right to health. While it may be the case that a small number of EPSs obtain profit via what he calls virtuous actions,[45] most patients at HUV were enrolled in health insurance that systematically engaged in "perverse actions," that is, practices that seek to fulfill their short-term contractual obligations by denying or deferring patients' access to medical services—even covered care—which end up pushing these institutions into a never-ending cycle of financial crisis (Abadía-Barrero 2022).

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Felix puffed his cheeks and quickly loosened his tie knot.

"*Pelao* [Kid], please pay attention to what I am going to say. In Colombia it is possible—even for the poorest of the poorest—to live longer and get treated for diseases like cancer. Look," he continued, "our health care system may not be perfect, but it is one of the best in the region, and has many advantages compared to what existed before 1993.[46] Back then health care was a privilege just for the rich."

Felix was referring to a moment in Colombian history when universal health care did not exist. Before the 1993 health care reform, the poor had to beg for services at facilities that were like charity hospitals.

He carried on with his monologue. "Nowadays, the wealthy pay for the poor's medical services. It is a form of economic solidarity. This kind of setup guarantees a permanent cash flow that allows everyone to get treated. Look around," he said, while turning his head and pointing at the crowded waiting room. "What kind of people do you see?" Immediately, he answered his own question with another one: "Not the wealthiest, right?"

Although I was unsure where Felix was heading with his spiel, I nodded my head.

"Well, today patients like them have the right to access medical services," he elaborated. "In addition, there is a long list of drugs that health insurance businesses must provide.[47] In the case of cancer, this formulary includes brand-name and expensive medications such as Glivec or Herceptin—top-notch drugs. And all the drugs in the list are usually free of cost for most patients. Isn't this considered social progress?" Felix asked, in a patronizing tone. "Do you think most patients in the US, for instance, would be able to access chemotherapeutic drugs without going bankrupt?"

He checked his watch.

"Let me say it again: Nobody in this country—do you understand?—nobody can deny patients the right to treatments and drugs, especially if these services have been prescribed by a physician and indicated by the medical literature. The law is on patients' side."

Suddenly, a nurse waved at Felix, who grabbed his wheeled Samsonite suitcase and stood up. The gesture confirmed the arrival of the oncologist Felix was waiting for. Before disappearing into the consultation room area, he mused, "Of course, no health care system is perfect, not even U.K's, Canada's, or Costa Rica's. Resources are always limited, after all. So money should be allocated wisely, especially in an underdeveloped country such as Colombia. In other words, you must make difficult decisions at some point. And some people will be unhappy. That's how things are."

He approached me and mumbled, "Most patients think the government should be like a *madre* [mother] whose role is to care for her children, to provide the *canasta básica* [basic consumer goods]. It seems they [patients] don't remember how bad things were prior to Ley 100. If you ever come across these individuals, just be aware they like to complain and criticize, you know. Is there corruption? Well, yes. Of course, there is corruption everywhere. You know, there is a lot of *robadera* [theft]. Sometimes not even the government knows exactly what happens with the billions of pesos it pays to EPSs. We just need to come to terms with it. Perhaps this is the price we pay for having one of the health care systems with lowest out-of-pocket expenses in the region, one in which everyone gets access to medical services—even high-tech treatments and technologies."

Felix's words puzzled me because they contrasted with what I had been systematically observing at public hospitals, where an overwhelmingly large number of patients seemed discontent with the quality of their medical services and the waiting required to access them. The cases I had witnessed at HUV echoed a crude, hopeless reality, a world in which cancer becomes synonymous with metastases and death. I can still recall very detailed images and scenes of fleshy and infected lesions, low-income patients with physical disfigurement, the smell of necrotic human bodies, or bodies undergoing unimaginable stages of decay while still alive.

Health care workers were not immune to this reality either. Physicians were utterly disgusted at the ways in which the financial logic shapes their medical practice while they are trying to do their best to care for their patients. Clinicians at HUV often stood behind picket lines because their salaries were rarely paid on time, because generic drugs were often scarce in the local market, because their low-income patients could not access prescribed treatments on time, and because many health insurance companies (EPSs) were engaged in systematic treatment deferrals and involved in corruption scandals.

Undoubtedly, Felix was a seasoned pharma rep, knowledgeable about the health care system and aware of patients' and doctors' frustration and exhaustion. Were our versions of the health care system informed by different events? Even though we were chatting at the same hospital, seemingly surrounded by the same kind of patients, and their desperation and exhaustion, we seemed to be stubbornly referring to different worlds.

These worlds of biomedicine, in fact, do coexist in Colombia.[48] Yet they rarely cohabit. By law, for instance, all Colombians should have access to any hospital, regardless of their ability to pay. However, not everyone may manage to inhabit the same examination rooms or get access to the same physicians, even at the same hospitals. Hence the Spanish phrase, "Estamos juntos pero no revueltos" (Together but not jumbled).

This book sets out to explore this impossibility of cohabitation (the historical impossibility of being revueltos) and analyze what cancer becomes at different intersections of public and private hospitals, health insurance regimes, medical practice, and patients' socioeconomic statuses.

China Miéville's fictional work *The City and the City* (2010) helps me reflect about different worlds of cancer care that coexist while failing to cohabit. In his novel, Miéville writes about two cities—Beszel and Ui Qoma—that occupy the same physical space but are understood as different by their residents. As parallel cities, they exist side by side but rarely come closer or get jumbled. Inhabitants of these cities are educated to recognize features of the other city, even when they have not seen or experienced them firsthand. Disregarding this separation, Miéville writes, is a terrible crime for the people who live and work in these places.

As someone who grew up in Colombia in the 1980s and 1990s, the description of Beszel and Ui Qoma reads eerily familiar. Colombia, after all, is one of the most unequal countries in the hemisphere, and it is known for its extremely classed practice of medicine (Hernández 2002; Ewig and Hernández 2009). Its inhabitants' lives and deaths are typically shaped by *estratos*, or strata, a caste-like system of socioeconomic classification that is correlated with the kind of neighborhoods we live in, the amount of taxes and utility bills we pay, the health insurance regimes we get enrolled in, and, therefore, the quality of medical services we receive. And because these socioeconomic divisions are so deeply ingrained in the Colombian imaginary, they have turned themselves into something quotidian—second nature.

Think about the differences between public and private hospitals. While public medical settings like HUV have been on the brink of bankruptcy many times over the past two decades, private hospitals such as Valle de Lili have managed to thrive financially, building state-of-the-art facilities and acquiring cutting-edge technology for the treatment of cancer. It has been awarded the Joint Commission International Accreditation—the world standard in world health.

Ethnographically, these differences became evident every time I left Valle del Lili and entered HUV. I would literally travel across worlds of care, through different infrastructure, technology, medico-insurance bureaucracy, and, of course, prognoses. Even the dress codes and Institutional Review Board (IRB) protocols I followed at private and public hospitals were markedly different.

And, of course, I was struck by the fact that these worlds do not usually get jumbled. Even if they are in the same neighborhood, within blocks of each other, these worlds—and the patients in them—are juntos pero no revueltos. In Jairo's case, for instance, getting transferred to Valle del Lili was highly unlikely; his EPS had no contractual agreements with its oncology department. Conversely, for patients who regularly get medical services at Valle del Lili,[49] switching to HUV may be perceived as a downgrade in care.

Don't get me wrong. Having some of the most cutting-edge hospitals in the region is great news for so many patients who are currently fighting cancer, or those who will develop it at some point in their lives. Hospitals like Valle del Lili have been conceived and built with good intentions. I have no doubt about it. However, in the aftermath of the neoliberal restructuring, private and public settings must compete with each other in the health care market; that is, they are expected to attract a higher volume of patients and sign contractual agreements with the most competitive and financially robust EPSs on the market. In addition, hospitals, like any other businesses, must follow the same premise that has informed public health policies in Colombia since it was a Spanish colony: large investments should be organic to urban areas.[50] After all, investing billions of pesos in the construction of a third-level hospital somewhere in the Pacific region would be an irrational decision from the point of view of profit.

A NOTE ON METHODS

After completing the coursework for my anthropology PhD program in Davis, a placid college town in northern California, I returned home to Colombia in 2011 for two years of ethnographic fieldwork in Cali, followed by shorter visits in June and July 2014, June and July 2017, and June 2018. There I spent countless hours observing, listening, and taking careful notes at the intersections of hospitals, health insurances, restaurants, and patients' homes. In addition to its manageable size (2.5 million inhabitants), I chose Cali as my field site because it is located among some of the most neglected areas of the country, where third-level public hospitals are scarce or nonexistent. For patients who struggle to find comprehensive medical care in southwestern departments like Cauca, Chocó, and Valle del Cauca, Cali's HUV is their default destination. Crucially, this influx of rural and low-income patients usually means doctors at HUV are exposed to a wide diversity of pathologies, even rare conditions that are unique to tropical areas. These features, according to physicians I interviewed, make this hospital an exceptional destination for medical training.

When I first arrived in Cali, I was granted access to Valle del Lili. My first interlocutor was a palliative care physician, whom I followed for a couple of months until she was suddenly diagnosed with a type of blood cancer. As soon as she began her aggressive treatments at this hospital, which would eventually put her in remission, I found myself reassessing the feasibility of my original ethnographic plans. During this interim, I was introduced to Dr. Masa. With his patience and support, I transitioned to HUV and was able to successfully complete my ethnographic research.

Inspired by a growing body of work on hospital and clinical ethnography (Livingston 2012; Street 2014; Stonington 2020a, 2020b; Smith-Oka 2021; Abadía-Barrero 2022; Singer 2022), I closely followed five senior oncologists at the above-mentioned hospitals. Dressed in a white coat, I observed how physicians conducted physical examinations of patients, asked questions, evaluated their symptoms, read and interpreted lab tests and imaging technologies, gave diagnoses, and wrote prescriptions. Even though cancer can be transformed into a chronic condition with the appropriate treatments, the vast majority of patients I came across at HUV had metastatic cancers, typically stages III and IV.[51]

I joined patients as they went back and forth between health insurance offices, pharmacies, hospitals, and their homes. While I was able to conduct multiple semistructured interviews with at least twenty-five patients, I ended up conducting intensive fieldwork with only eight of them. This smaller group taught me a great deal about exhaustion, futility, treatment deferrals, and dying. I stayed with them in waiting and consultation rooms, health insurance offices, and their homes. And, finally, I attended their funerals.

Because I have no medical training and I have not been a cancer patient, my participation in this research was inherently partial. Therefore, this book cannot fully grasp the challenges of enduring cancer in Colombia, especially from the point of view of someone getting chemotherapy infusions or lying down on a bed at a public hospital. In addition, my own background (and relative privileges) as a middle-class male *bogotano* has inevitably informed my analysis and shaped my interactions with so many of my interlocutors, as well as the moments of silence that unfolded between us.[52] Yet I was still able to "participate" in some of the quotidian routines: helping patients fill out hospital forms, requesting doctors' signatures on behalf of patients, photocopying clinical histories and insurance forms, calling the next patient in line, and joining physicians at social events hosted by the pharmaceutical industry.

My ethnographic observations and conversations, however, were not only restricted to oncology outpatient wards. To learn about cancer, I also followed doctors to informal events: social gatherings, conferences, lunches with pharmaceutical representatives, and breakfast meetings—where clinicians seemed more open to talking about the intimacies of their work. From technical inquiries about clinical procedures to patients' prognoses and ethical dilemmas, social events were ideal moments for asking questions I did not feel comfortable voicing during consultations.

Finally, I was able to interview three health insurance representatives who worked with EPSs for the poor or for unemployed individuals (the subsidized regime). Through them, I learned about the financial inner workings of these businesses, the burdensome paperwork, and the financial criteria informing their decisions to authorize treatments—especially those deemed high cost. By paying especial attention to their encounters with cancer patients, my book describes how the insurances' bureaucratic, financial and judicial dynamics shape medical practice, and its consequences.

Informed by anthropology and science and technology studies (STS) research on complexities (Mol 2002; Law 2004; de la Cadena 2015; Haraway 2016), this book is an attempt to describe the biomedical treatment of cancer in Colombia and its paradoxes. Out of these descriptions and encounters, ethnographic concepts arose (Strathern 1991, 2020; de la Cadena 2015, 2021) that helped me think how biomedical cancer care practices are shaped by patients' positionality in an economy of health care and analyze the relations between jurisprudence, health insurance companies, and patients' socioeconomic conditions under neoliberalism. All these elements participate in the intersections of health care I conceptualize.

Interim I

Update on the Latest Health Care Reform Project

Many efforts have been made since 1993 to counteract the effects of Ley 100. None, however, has attempted to reconfigure a world of care beyond the market rationale and its incentives for unlimited growth—often in tension with the logic of care. Until now.

In 2022, as I was completing the revisions for this book, Gustavo Petro, a former guerrilla, was democratically elected the first leftist president in Colombia. Such an unprecedented reconfiguration of political forces was initially accompanied by widespread hope and a sense of vindication for many Colombians. After nearly fifty years of civil war, the country was long overdue for a profound transformation. As a candidate, Petro had pledged that if elected, he would eliminate the inequities that plagued the current health care system and make sure the fundamental right to health is guaranteed for every Colombian. In early 2023, a few months after being sworn in, Petro and his minister of health, Carolina Corcho, filed with Congress the promised health care reform.

If approved, the reform will dismantle Ley 100 as we know it and unleash one of the most radical transformations in Colombia's health care system since 1993. Some of its most important goals are divesting EPSs of their financial and intermediary roles and limiting their vertical integration practices;[1] strengthening primary and preventive medicine services, especially in rural areas; and creating a public and online system of accountability through which individuals can track how taxpayer money is being spent on health care. As of the beginning of 2024, the bill is still making its way through Congress. Its most ardent critics argue that the reform would push the health care system into uncharted territory.

While the reform's goals may be well intentioned and much needed, it is not yet clear whether the end of neoliberal reforms, along with EPSs and their intermediation role, would prove to be sufficient measures for ensuring equitable and prompt access to quality medical services, particularly for lower-income Colombians (see Castaño 2023). This book seeks to present a reality in which we are trying to build alternatives to these kinds of policies. As Andrew Goffey has put it in the introduction to Pignarre and Stengers's *Capitalist Sorcery*, "For another world to be possible, really possible, the reality of that possibility effectively implies that we don't know quite how to respond, how to continue, how to inherit" (2011, x). Thus, efforts to create a new health care system are rife with complexity, and there is so much we need that we don't have yet.

An ecology of practice could inform these attempts. An ecological perspective, following Stengers (2005b, 183), assumes "coexistence and co-becoming as the habit of practices." That is, the common bioeconomic interest in treating and curing cancer, for instance, is informed by practices that have other interests as requisites. From an ecological perspective, any attempt at transforming the health care system would need to take up the many perspectives of all actors, however incompatible they may seem.

Cancer Intersections does not offer to solve the Colombian health care crisis.[2] Proposing and implementing "solutions"—I believe—is a goal better suited to other kinds of experts. My training as a cultural anthropologist has largely revolved around exploring the conditions that have made facts or realities possible and the ways those realities are disputed or maintained. Drawing inspiration from the writer and mystic Rupert Spira, this book does not ask questions and then provide definitive answers to them. It rather seeks to ask questions in order to expose our assumptions and dispel them. Hence, my intention is not to prevent a future crisis but rather to explore ways to be present in the midst of challenging times (Haraway 2016), when the old is dying and the new is struggling to be born, paraphrasing Antonio Gramsci (1999).

1

Out-of-Sync Cancer Care

Swarms of motorcycles move onto the sidewalk and dodge pedestrians as they try to escape the chaos on the street, while food vendors run in the opposite direction looking for customers stuck in traffic. My friend Pepe and I are sitting on the curb of Calle Quinta (Fifth Street) in north Cali, across from HUV and the municipal morgue and just east of the emblematic Pascual Guerrero soccer stadium. We have nothing better to do than stare at the rush hour traffic and commotion unfolding before us.

After waiting in line for almost two hours, we are finally getting closer to the health insurance main entrance. “We must keep waiting. El que se desespera, pierde [The one who gets impatient, loses],” Pepe says. I turn my head and see a line of insurance enrollees extending along Calle Quinta and around the block—just across from one of the many funeral homes in the area. Most of the enrollees are holding folders and plastic bags packed with copies of clinical histories, prescription forms, labs, and pharmacy receipts. They are low-income patients seeking authorization to access their prescribed medical treatments.

Pepe, forty-five, is a man from a low-income background. He had been diagnosed with an “infiltrating and ulcerated adenocarcinoma” in his stomach (commonly known as gastric cancer). Finally, after waiting five months to be seen by an oncologist, he was prescribed eight cycles of an aggressive multidrug therapy: 70 mg of epirrubicin and 190 mg of oxaliplatin (injectable cytotoxic drugs) to be administered every 21 days and 2,000 mg capecitabine tablets to be taken daily for 14 days. His insurance company, however, after a delay to process the request for coverage, responded that it would only cover him for oxaliplatin—the cheapest of the three drugs. This would have resulted in an incomplete chemotherapy

MAP 2. Map of north Cali and the neighborhood where HUV is located. Credit: Google Maps.

regimen, so Pepe's infusion was postponed, and he had to wait to return to the doctor for a new prescription. By the time he saw the doctor, lab work revealed that his condition had worsened and that he needed treatment different from the one originally prescribed. The doctor wrote a prescription for a new regimen, and this was again submitted for approval to the insurance company.

Pepe shares his frustration with me: "They [insurance representatives] always have an excuse for not providing my treatments on time: the doctor's signature is missing; the xeroxed copy of the prescription does not correspond to the original; the stamp is not clear; there is a wrong date on the required forms, things like that.

"Things will be different this time," he says. He has made sure to fulfill each of the insurance requirements before submitting his chemotherapy request. "The more stuff you bring," he muses, "the fewer excuses the insurance reps have for postponing or denying treatment applications."

Inside the office, space is at a premium. To accommodate the massive influx of people, an overwhelmed security guard tries to change the straight line that had moved along Calle Quinta into a zigzag pattern. A series of shorter lines with sharp turns would maximize space inside the office while extending waiting times for enrollees and increasing their frustration. Waving his hands, the guard gives directions to the newcomers. "Make a line over this side and over that other too

[Háganme la filita por este ladito y por este otro]," he says, using his lips to point the way. "Do it in a zigzag-like manner, do you understand? [Hágale a lo zig-zag, ¿si me entiende?]." From now on, the time it will take us to reach the insurance reps will depend on how many sharp turns are formed inside the facility. In a loud voice, the guard asks Pepe and me to move forward: "You two, please follow the line. Make room for the people coming behind [Ustedes dos, sigan la fila. Hágan campo para los que vienen atrás]."

Toward the front of the room, behind a thick security window, two insurance representatives are busy doing preliminary reviews of enrollees' treatment applications. Their role is to make sure all the hospital and insurance paperwork has been correctly filled out by enrollees and all the documentation is properly attached.

As we zigzag in the room we seem to be getting closer to the reps while also moving away from them. After spending two hours roaming around the waiting room, we are about to reach the customer service area. A female rep waves at us. Pepe clears his throat and steps forward. While holding a plastic bag containing his clinical history, he makes a noticeable effort to bend low as he tries to reach the narrow opening between the security glass and the metal counter.

"Good day. Can you hear me okay? [Si, buenas. ¿Ahí me escucha bien?]," Pepe asks. Without much preamble, he gets to the point: "Look, *mami*.[1] I live far away from this office, and every time I come here it is just a waste of time and money." If space is at a premium at this office, frustration is overflowing it. Pepe has been enduring extraordinary pain in an ordinary way. For him, this is just another instance of zigzagging at the insurance office. But it is his third attempt to get his chemotherapy approved.

"Today I am not leaving until you guys authorize my treatment. Do whatever you need to do, but make sure I get the drugs. Not tomorrow, not in a month; today!" Pepe says loudly. Frustration, for him, has become a way of talking about living on his way to dying. The representative looks at him, perplexed. "Please, Mr. Pepe, calm down. Let me find out what's happening with your treatments." My friend slides his paperwork through the narrow opening. The rep skims the documents and types Pepe's *cédula* (national ID) on a computer to retrieve the most recent information about his claims.

While looking at the computer screen, the rep says, "Mr. Pepe. Thank you for your patience. Based on the notes left by my colleagues, nobody is saying your drugs could not be authorized. The problem is that epirrubicin is out of stock in our partner pharmacies. Generic capecitabine is also scarce, and only Xeloda is available to replace it; but it costs five times more than the generic. So it's not a problem of approval but of drug unavailability."

She turns from the computer screen and looks at Pepe.

"You have filled out all the forms correctly—I can tell. The original prescriptions are here [she points at Pepe's plastic bag], as well as a copy of your medical history. There is nothing missing. The problem is that the medications are still out of stock in our partner pharmacies. We will give you a call as soon as the rest of your drugs become available."

Pepe looks at me and grumbles, "Do you see what I am talking about? We have just wasted the whole day, for nothing. These are the frustrating *vueltas* I must do all the time."

Vueltas in Spanish means to turn around a fixed axis or move in circles without a sense of direction. It is one of the most common words used by low-income patients to describe the exhausting process through which they try to access medical services in Colombia. It refers to the burdensome paperwork, futile waiting (Auyero 2012), and bureaucratic itineraries (Abadía and Oviedo 2009), the trips back and forth between the health insurance office, pharmacies, and the hospital. These vueltas are part of the absurdities occurring in the Colombian health care system. They seem painfully unrealistic, as if taken from Franz Kafka's *The Castle*, a novel in which the main character tries again and again to progress in his work but never moves beyond the Castle's snowy environs. Inspired by Kafka's narration of futility and absurdity, I use the word *vueltas* to describe how low-income patients must seek access to high-cost medical services; it emphasizes constant movement that leads nowhere amid pervasive uncertainty.

Vueltas are an expression of what I encountered regularly during fieldwork. Pepe's story illustrates how, after the neoliberal restructuring of the Colombian health care system in 1993, caring for someone with cancer or cancer patients themselves became entangled in a relationship between time and social class.[2] When cancer patients are poor and prescribed treatments are classified as high cost, they endure a contradictory temporality between the imagined time of biomedicine, broadly understood in terms of clinical protocols,[3] the time needed by health insurance companies and their officials to determine whether the high-cost treatments are necessary, and the time when receiving chemotherapy would be "beneficial." Vueltas express the process by which patients try to bring these very different rhythms into alignment, into synchrony.

Low-income patients like Pepe usually access their treatments after waiting for several months and after filing tutelas against insurance companies. When these patients finally gain access to treatment, however, it is often too late: the tumors have already metastasized, and the specific chemotherapy recommended for earlier stages of cancer has become a potent chemical abrasive, its effectiveness now limited to extending life for a few weeks or months. Ironically, it is often at such a critical moment that the state intervenes to try to save a patient's life. In this way, the state makes itself "available" to citizens, not in a real sense, but in a way that satisfies the "technical rationality" required by the bureaucratic structure of its neoliberal health care system (Weber 1978).

My focus in this chapter is on physicians' practices and interpretation of their work and their relationship with health insurance companies. I discuss how they interact with the local medical bureaucracy and how they use what they have at hand to guide their practice and, therefore, medicine. How do oncologists provide care when they get caught between the time needed by insurance companies to get a financial return on their investments and the time when their prescribed chemotherapy would be beneficial for patients?

I follow "timing" through two interrelated bureaucratic-medical processes: *deferral* and what I call *therapeutic disjunctures*. The former is the official name given to temporary denial of health services by an insurance company while it investigates whether its money will be spent efficiently; the latter describes the bodily harm caused when as a consequence of deferrals, the treatment regimes become "desynchronized" with the imagined time set out in oncology protocols.[4] Building on scholarship on the coproduction of biomedicine and capital (Sunder Rajan 2006, 2012, 2017; Cooper 2008; Dumit 2012), I first analyze the process of deferral and how it became naturalized after the 1993 neoliberal restructuring and then attend to therapeutic disjunctures and discuss how low-income patients and their doctors struggle to "catch up" with the imagined time of oncology.

LEY 100 AND UNIVERSAL HEALTH CARE

Until 1993, Colombia's health care system was composed of state-funded social security based on a supply model whereby public hospitals received resources directly from the government and were responsible for providing health care, particularly for low-income populations (Hernández 2000; Plaza 2001). At that time, enrollment in the social security system reached only 21 percent of the population (Mangrum 1999) and was limited to public officials and workers at state institutions. Low-income populations were unable to access most medical services. Most specialized and high-tech medical services were generally limited to those who could afford to pay for them out of pocket and those who had policies with private health insurance companies, or medicina prepagada. Patients who required complex treatments had to commit to unpayable loans or sell their belongings. Wary of the financial collapse of their patients, Alejandro Gaviria (2020) explains, physicians tended to avoid standard medical protocols for individuals unable to pay for them. Simply put, "prior to 1993, patients who had the means, paid. Those who didn't, begged for them" (Hernández 2002, 992).

Arguing lack of fairness, corruption, and inefficiency, the Colombian government enacted Ley 100 in 1993 and transformed the model of health care delivery. Its main goal was to guarantee universal access to medical services—regardless of preexisting conditions, socioeconomic backgrounds, and diagnoses—through mandatory health insurance plans provided by EPSs.[5] As explained in the introduction, these insurance companies are a mix of public and private investors that are intermediaries between the government, health care providers, and patients. The creation of these companies helped consolidate the meaning of health as an individual responsibility to be purchased (Abadía-Barrero 2022).

This transformation was part of a larger neoliberal trend across Latin America during the 1980s and 1990s (especially those countries burdened by massive foreign debt), which promoted the "free" market in health care, emphasized privatization of hospitals and health insurers, and sought to limit government involvement (Cueto, Brown, and Fee 2019).[6] There are two major reform strategies I want to highlight: the separation of the financing and provision of health care and the promotion of competition among providers (Iriart, Merhy, and Waitskin 2000; Armada, Muntaner, and Navarro 2001; Castaño 2023). Unlike the conventional public sector, the separation of financing from provision—according to its advocates—would allow "buyers" and "sellers" of medical services to act independently. In this model, sellers, like hospitals or health insurance companies, "are expected to compete amongst themselves for the preference of buyers" (Armada, Muntaner, and Navarro 2001, 735).

Chile is the best-known example in Latin America of this transformation. Its health care system has adopted privatization as the main economic practice, which includes a mandatory insurance model that combines private and public companies competing to attract buyers (Han 2012; Goic 2015). It is also characterized by a marked segmentation in the funding structure. However, this model under which citizens voluntarily opt for coverage by either public or private insurance companies, has led to growing inequities, which has prompted the Chilean government to introduce major reforms in health care provision (Bastías et al. 2008; Gattini 2018).

In the case of Argentina, during the 1990s the government sought to introduce changes in the universal system—private and public, yet highly segmented and controlled by large corporations (Abeldano 2022). Today the major health care problems in this country are related to both equity and efficiency, as in other countries in the region (Rubinstein et al. 2018).

Likewise, in 2004 Mexico created a new health insurance program known as Seguro Popular, which sought to guarantee health care access to marginalized populations and also to reduce high-cost health expenditures (Frenk 2006; Smith-Oka 2020). Medical care in Mexico hence shifted from a system that managed health through public funds to a neoliberal system based on patient responsibility (Homedes and Ugalde 2009; Reyes-Foster 2018; Singer 2022). The results have not been translated into better health for Mexicans,[7] mirroring the stark social inequities that have shaped the history of Latin American countries.

Brazil took a somewhat different path during the 1980s. It unleashed a health care reform "that culminated in the recognition of health care as a right of citizenship and the creation of the public, universal Unified Health System (SUS) enshrined in the constitution of 1988" (Vieira and Azevedo e Silva 2019, 2). But implementation has proven difficult. During the 1990s, neoliberal reforms were adopted. In sync with other reforms in the region, the Brazilian government sought to separate funding from the provision of services, assemble basic service packages, and give priority to the care of low-income citizens.

Despite several similarities with these countries, however, the Colombian case was the most innovative at the time (Castaño 2023) and was often seen by health policy experts as having superior policies to its neighboring countries, except Costa Rica.[8] Ley 100, after all, not only implemented regulated competition in the administration of public and universal health insurance and in the provision of medical services but also developed a model of financial solidarity between rich and poor populations. As mentioned in the introduction, health insurance enrollment was based on two EPS regimens: citizens with higher payment capability are required to purchase health care insurance plans in the contributive regime (11 percent of their income),[9] which consists of a standard benefit package. In addition, 1.5 percent of their income is transferred to a fund that, along with other sources of financing such as taxes, is used by the state to pay subsidized policies for people like Pepe, who are enrolled in the subsidized regime and lack the ability to pay. This model of financial solidarity sought to guarantee that no Colombian would ever be denied access to prescribed medical services due to financial limitations or go bankrupt as a result of expensive hospital bills.

Thirty years after the 1993 reform, however, universal health insurance has failed to guarantee the right to health, understood by Olivier and Mossialos (2004) as equal access to medical services by patients who have equal health needs. Individuals who are poor and suffer from high-cost diseases such as cancer struggle to obtain care due to the government's reliance on private insurers, which delay care until cancers are often beyond the point of effective intervention.

This is partly because the EPS's profit maximization model is based on fiscal cautiousness, that is, being vigilant about the claims filed by high-cost patients. While Ley 100 prohibits these companies from denying their enrollees access to medical services, it makes no explicit reference to the timing of the provision of these services. The market decides whose diseases get cured or transformed into chronic conditions and whose bodies are not worth treating. As Clara Han has written in *Life in Debt* (2012), the market becomes the main form of health care governance, the principle on which life itself is structured.

Thus, making patients waste time becomes a mechanism for maximizing profit and successfully meeting the health care system's bureaucratic procedures (Abadía and Oviedo 2009; Mulligan 2016). This is what so many patients like Pepe experience when their high-cost chemotherapy regimens are less likely to be provided according to their oncologists' timelines. Rather, access to high-cost chemotherapy infusions is systematically "spread" over time, from every few weeks to every several months. Patients are then pushed into a whirlpool of stress and emotional exhaustion, which recent clinical research has associated with increased risk of developing certain cancers and more aggressive metastases (Yang et al. 2019).

WASTING TIME, MAXIMIZING PROFIT

In general, the insurance business model is about managing risk, or pooling risk from individual payers and redistributing it across a larger portfolio. From life and vehicles to houses and health care, most insurance plans generate revenue in two ways: by charging premiums in exchange for levels of coverage, "peace of mind," and by reinvesting part of these funds in other interest-generating assets.

In this sense, insurance companies function like investment banks, whose mode of profit maximization, according to the US economist Paul Krugman (2022), is often in tension: the desire for liquidity—immediate access to funds—and the need to undertake long-term investments that can be converted into cash with difficulty. Like banks, health insurance companies are often caught in this balancing act; they need to be vigilant about the funds they must keep liquid to pay for medical claims and hospital bills and those that must remain as illiquid assets.

Hence, I contend, banking and health insurance companies make a profit by reconciling the otherwise incompatible desires for short-term liquidity and long-term investment. In the case of banks,[10] again following Krugman (2022), this practice usually works because only a small percentage of their "depositors wants to withdraw their funds at any given time." A similar dynamic is present in the health insurance market because only a small fraction of enrollees are expected to fall ill at the same time—and to be diagnosed with the same high-cost diseases. If these conditions are given, insurance companies would disburse less money on claims and therefore be better positioned to transfer more illiquid assets to the financial system (usually a long-term investment strategy). In the event costs of claims go up, premiums would need to match them.[11]

In the context of Colombia, however, EPSs were created to guarantee the right to health of all citizens, meaning that these businesses must enroll any Colombian who requests it. Consequently, they are limited in terms of their risk assessments of enrollees' age or preexisting conditions, for instance, and are prohibited by law from denying them access to prescribed treatments, especially if their lives depend on these services.

In exchange for enrolling Colombians, the government pays EPSs the equivalent of a premium. This payment is known as Unidad de Pago por Capitación (UPC), or annual fee per enrollee, which in 2016 was approximately US$220 for the subsidized regime.[12] With this amount, EPSs are expected to cover enrollees' annual examinations, treatments, and hospitalization costs. This fee is also used to cover EPSs' administrative and operational costs. In other words, these businesses are expected to maintain a positive balance between the premiums they get paid annually (UPC) and the treatments they must provide to guarantee citizens' right to life and health. Any surplus amount is to be reinvested in the EPSs themselves, growing their market share and generating profit.

Because an EPS cannot legally deny access to prescribed treatments or turn down potential enrollees because of preexisting medical conditions, profit is often generated by delays in outgoing expenses. In other words, the EPS business model revolves around discouraging the provision of numerous high-cost medical services—through claims—at any given time.[13]

"If they can manage to disburse late payments to hospitals and doctors, and defer the provision of high-cost medications for long periods, the UPC they get paid per enrollee would yield savings in the financial system," explained Dr. Artesano, a palliative care giver who works with terminal patients at HUV. While these companies are expected to provide care for all patients, they also must be vigilant about the limited money allocated as UPC.

Dr. Artesano continued his explanation: "Imagine you hire a contractor to renovate your home. You disburse part of the money in advance as proof of the business agreement. Only when the job is thoroughly completed, and you are entirely satisfied with it, you disburse the rest of the money. If, on a different scenario, you decide to pay up front all the money, way before the renovation is completed, the contractor may take longer to finish or do a sloppy job." Similarly, in his opinion, which is shared by other physicians, while insurance companies in Colombia are legally mandated to enroll patients regardless of their health status and ability to pay, there are limited financial incentives to provide prompt and quality care. After all, insurance companies basically get paid up front, way before the "job gets done."

Following this physician's reasoning, the bureaucratic process required for providing medical services and being vigilant about money proceeds with a specific understanding and relationship to time: "bureaucratic time." This goes against the understanding and relationship to time that appears in doctors' protocols, as well as in cancer patients' bodies: "biomedical time." Before providing high-cost treatments, insurance companies must take the time to carefully review their patients' clinical histories to make sure doctors' requests are financially "sound." This means keeping authorization costs as low as possible (Giraldo 2007; Vélez 2016) while providing the most effective (often high-cost) chemotherapeutic regimes that bodies can stand, or at the very least, prolonging their life for a time that "justifies" such expenditures. Therefore, making patients waste time, if not explicitly intentional and directly profitable for the insurance companies, is a reflection of their cautiousness. What patients see as the EPSs making them waste time, leading to delays in treatment and a reduced chance of success, the EPSs may see as the time they need to increase profit and spend wisely. This is an economy of growth that is out of sync with cancer growth.

BUREAUCRACY, CHEMOTHERAPY, AND CAPITAL ACCUMULATION

As the worlds of biology and business logic move closer together, it is becoming difficult to think about the life sciences without invoking concepts of political economy such as production, value, and growth. Here I draw inspiration from scholars such as Joseph Dumit (2012), Kaushik Sunder Rajan (2006, 2017), and Melinda Cooper (2008) who have sought to understand the coproduction of biomedicine and capital, a process through which life is increasingly appropriable by capital.[14] Sunder Rajan (2012, 326), for instance, has analyzed how "the pharmaceutical industry functions less and less as discoverer of new therapy and more like investment banks, controlling, regulating, and betting on the flow of capital." This process of shifting corporate strategy in terms of financial risk calculus, he claims, results in the separation of value from considerations of patient needs. This creates what he refers to as a structure of crisis for patients. Likewise, in Colombia there is an appropriation of medical time by business time, which results in insurance companies maximizing profit by providing cheaper drugs—and perhaps drugs of lower quality—or deferring the provision of high-cost chemotherapy or other treatment until patients are often too weak to receive them.

To understand the relationship between the course of disease and the time needed by insurance companies to maximize profit, I focus on chemotherapy, often the most expensive, uncertain, and toxic technology employed for cancer treatment (Keating and Cambrosio 2011; Timmermann 2014). Managing its side effects is quite often a challenge for doctors; its therapeutic index—the ratio between the toxic dose (maximum tolerated dose) and the therapeutic dose—is most favorable when the disease is in its early stages. Crucially, as time passes and the cancer becomes more aggressive, chemotherapy's effectiveness decreases and can even turn into harm, like a concentrated poison.

These questions—the temporal urgency of oncology and the toxic and potent nature of treatments trouble cancer patients in Colombia, as they do elsewhere. From the urgency of rapidly dividing cells to the hours spent at insurance offices and receiving chemotherapy infusions, "a cancer diagnosis hurls one into a therapeutic pipeline at great speed," Julie Livingston (2012, 19) explains. In the US, Lochlann Jain refers to this temporal urgency by explaining how the possibility of this disease pushes people to use their savings to pay for costly screenings and medical interventions that promise to catch cancer "in time." In the US, where health care is not universal,[15] patients often have to pay out of pocket for costly treatments. In this context, postponing medical spending to a later time to treat a growing tumor would be an irrational choice; patients will not be able to enjoy their savings once their tumor has metastasized and their physical health has deteriorated (Jain 2013). What is the point of waiting, therefore, if patients in the US could use their savings now—or at least apply for credit—to maximize their chances for living longer?

In countries of the Global North such as South Korea (Nelson 2016) and France (Sarradon-Eck 2015),[16] patients talk about the shame of not having done self-exams, delaying diagnostic tests because they are too busy, or not wanting to ask more of already overworked doctors. They talk about lost opportunities. *What if* they had acted earlier, undertaken self-exams, or participated in screening, or reported a suspicious lump to their doctor? For low-income patients in cities like Cali, it is not so much the patient who decides to wait or not: the health care relationship does. Think about Pepe. For him, the *what if* lament about the past is transformed into a more hopeful, yet uncertain, *when would* interrogation of the future—or a *hopefully they will* desire. The temporal puzzle is less about what patients could have done differently in the past than it is about preparedness and future expectations. Patients I met rarely regretted not checking their symptoms earlier. Rather, they complained about having to waste time and endure bureaucratic obstacles in order to access treatment.

Patients are pushed into what Elizabeth Povinelli (2012, 127) calls a slow process of "getting burnt out." She is not thinking about taking a life but about the biopolitical condition of physical and emotional exhaustion resulting from the waiting required to successfully meet the system's bureaucratic and financial procedures.

In *The Utopia of Rules* (2015), Graeber shows how bureaucracy is increasingly informing every aspect of our existence. From myriad university administration forms and humanitarian red tape (Gupta 2012) to burdensome health insurance paperwork and real estate transactions, "markets simply did not emerge as some autonomous domain of freedom independent of, and opposed to, state authorities. Exactly the opposite is the case" (Graeber 2015, 9).[17] Neoliberal policies like the ones unleashed by Ley 100 have produced more regulations, more bureaucrats, and more policy. This apparent paradox is what Graeber calls "the iron law of liberalism," which states that "any market reform, any government initiative intended to reduce red tape and promote market forces will have the ultimate effect of increasing the total number of regulations, the total amount of paperwork, and the total number of bureaucrats the government employs" (9).

Here is where the paradox lies. In a capitalist system, paraphrasing Graeber, this is precisely what is not supposed to occur—yet it happens over and over.

This means that the bureaucracy encountered by most low-income patients is not simply an instrument for insurance companies' premeditated delay or control of the provision of services, but rather a constitutive practice of their financial rationality, of medical knowledge on cancer care, and even of the hospitals' rules. Practices, after all, do not simply describe realities but also tend to bring these into being (Mol 2002; Law 2008).

This is how biomedical cancer care becomes a local practice in Colombia, entwined in the bureaucratic practices of insurance companies (vueltas and treatment deferrals), the legal mandate seeking to guarantee access to medical services, and the biomedical understandings of cancer and patients' understandings of treatments.

Even though patients like Pepe may be "running late," they cling to the hope of accessing medical treatments and synchronizing the time of their cancerous condition with the imagined time of biomedicine. They know they have the right to access medical services. It is the law. But it is uncertain when this will happen, mostly because there is a marked disjuncture between law-as-text and law-as-practice (Greenhouse 2006). Thus, the possibility of accessing prompt medical services seems to be an illusion—the illusion of things being possible while in fact they are impossible.[18]

Recall that Ley 100 called for universal health care and access to medical services for all citizens. The violation of this mandate is—at least in theory—punishable by imprisonment and fines.[19] Refusal of treatment—as a way of making money—is not a legal option for insurance providers in Colombia. Instead, they make time (money) by deferring treatment and by using funds as financial capital. This is how the biocapitalist treatment of cancer for low-income patients emerges in Colombia—deferring treatment to avoid spending money inefficiently on low-income/high-cost patients.

RHYTHM AND THE IMAGINED TIME OF ONCOLOGY

"Everywhere where there is interaction between a place, a time and an expenditure of energy, there is rhythm," wrote Henri Lefebvre (2004, 15). This includes the interactions between physicians, medical protocols, patients, and health insurance practices. *Rhythm* derives from the Greek word *rhythmos*, "to flow." It is a sequential and associated timing of events within the flow of time. These events may be systematic and temporal arrangements of musical notes (Klemp et al. 2008) or physical movements and dance (Manning 2006). Think about the pulsations of the heart: diastole is the phase when the ventricles relax and refill with blood following systole (contraction). Diastole and systole follow a repetitive pattern; they can be anticipated.

Scott Stonington (2020b) has written about medical decision making in the US amid flows of urgency and partial information at an ICU. In the midst of uncertainty and urgency, he explains, there are several rhythms that inform clinicians' decision making. In the case of patients' physiological rhythms, Stonington draws our attention to some continuous forms of data like pulse oximeters that provide "second-by-second readings of arterial oxygen concentrations" (349) and others that are periodic, like blood pressure cuffs firing automatically and reporting results every few minutes.

Similarly, rhythm is intimately related to the biomedical time of cancer *and* the medical knowledge that handles it. The entwinement of both is how cancer emerges and is actualized as visible to treatment. The rhythm of clinical interventions—according to the oncologists I followed—should be in synchrony with the expected development of cancer and able to *move* with it. If the treating oncologist, for instance, is not provided with up-to-date data during examinations, patients may start lagging behind schedule, loosing rhythm and falling into a gap of time difficult to overcome as the disease progresses. If the information is late, it is like old data and hence belongs to past bodily configurations. In other words, dated information belongs to different bodies, so it is useless.

There should be synchronicity between doctors' imagined time for treatments, decision making, data collection via examinations and laboratory tests, and the biological time of disease as measured by medical technologies. Most prostate cancer patients with bone metastasis, for instance, must provide oncologists with blood work every few weeks in order to assess the levels of alkaline phosphatase in their bones (a biomarker that reflects metabolic activity of the tumor). And this blood work must be synchronized with a bone scan that adds a crucial visual component to the available numbers. This synchronization informs doctors' decision making and guides them in the next step of the therapeutic journey. It completes a phase in the treatment for prostate cancer—a rhythmic systole followed by a diastole.

Crucially, because the imagined time of biomedicine implies continuity and succession, clinical events unfold together. As Dumit has written in *Drugs for Life* (2012), knowing that one is at risk for developing a disease such as cancer leads to a series of tests and screenings, which usually yields answers but also the urge to conduct more tests. According to standard oncology protocols, men at risk of developing prostate cancer, for instance, should periodically have digital rectal examinations after the age of forty. If something unusual is felt during the exam, then a blood test is ordered to measure the prostatic specific antigen (PSA). If levels of this biomarker are suspiciously high, then a biopsy is taken from the prostatic tissue and studied under a microscope. A diagnosis is produced, followed by the prescription of a treatment. Here I am attempting to describe how the imagined time of biomedicine is set up. If cells show malignant activity and are still in early phases, surgery should be considered as the first-line intervention. If cancer has spread beyond an organ cavity or into neighboring tissues, then medical protocols indicate the use of chemotherapy and/or radiotherapy. Talking, palpating, conducting biopsies, diagnosing, prognosticating, prescribing: all these actions have a strict timing and rhythm in biomedical practice. Now let me provide a specific ethnographic example of how the rhythm of medical events unravels in a private clinic in Cali.

MELANOMA SYNCHRONICITY

Most of the physicians I shadowed at Valle del Lili, a state-of-the-art private hospital in Cali, tended to see a larger percentage of patients enrolled in EPSs for workers (CR) and prepaid insurance for the wealthier. The following conversation took place during a follow-up consultation between an oncologist, who asked questions and took notes, and a patient, who talked about a mole that had recently been excised from his right cheek.

"Have you taken all your medications in the order they were prescribed?" Dr. Ventura asked.

"Yes, I have, and I'm feeling pretty much recovered from my surgery," answered Antonio, while firmly holding his wife's hand. Antonio is a sixty-eight-year-old lawyer from Palmira, a city near Cali. He is a member of a historically wealthy family in the region. Four months ago, he was diagnosed with a cutaneous stage I melanoma in his cheek and was immediately referred to a surgeon for a complete resection of the mole.

"Fortunately," his wife said to me while Dr. Ventura palpated the patient's neck in search of suspicious ganglions, "doctors were able to remove it in time. We feel so grateful."

The surgical intervention went well, and the pathology analysis provided no evidence of suspicious cellular activity beyond the mole's margins. "The melanoma was caught *right on time*," Dr. Ventura reflected, as he continued examining the patient. "His prognosis couldn't have been more hopeful."

According to the patient's medical history, the standard oncology protocols were followed step by step and provided in synchrony with the pace of his growing tumor. The patient often knew what to expect after each treatment session and was able to prepare accordingly; there was a relative sense of certainty about the continuity of his treatments. Throughout the multiple encounters we had at the oncology wards, Antonio made it clear there had been no issues with his insurance, no delays in the provision of treatments, laboratory tests, or surgery. The biological time of the disease, the timing of the approval from the insurance company, and the imagined time of medicine seemed in sync.

Three months later, however, Antonio showed up at the examination room. When I saw him, I thought he had just come for a routine checkup. Dr Ventura examined him and wrote down an unexpected observation in the medical history: "Patient complains of progressive deterioration of vision in his left eye, floaters, and a visual field defect [a blank spot in the field of vision]." Clinical and imaging examinations were performed over the following week, and an ocular melanoma metastasis was diagnosed.

Antonio's ocular metastasis either went undetected or did not exist during initial examinations. Now the patient had to deal with one of the most lethal incarnations of cancer: metastatic melanoma. Surgery was not an option, nor would removing his eye guarantee that he would be cancer-free. His doctor had to find a less invasive treatment to prolong his life, at least for a few months.

I leaned toward the physician's desk and peeked at the computer screen. Dr. Ventura had logged in to the *Journal of American Oncology*'s database and downloaded a couple of articles. He skimmed the abstracts and immediately made a phone call to a pharmaceutical representative. He asked questions and took notes. After spending several minutes on the phone, the physician explained to Antonio, with some excitement, the recommended treatment for his type of cancer: "First of all, a tomography will be needed to assess whether a brain metastasis is underway. If a metastasis is found, oncologic protocols encourage palliative care resection and/or radiotherapy. If, on a more positive scenario, your brain has not yet been affected, I would then order a systemic treatment. And Yervoy would be the best drug for you. Studies have shown it slows down the biochemical activity of the tumor and offers decent rates of survival. You would have to spend several days at the hospital because we need to monitor the drug's side effects, which are stronger than ordinary chemo. Because Yervoy makes T cells more responsive to many stimuli (not just cancer cells), the drug can cause powerful autoimmune reactions in your body. If you agree to take this medication, chances are you will live longer."

Antonio asked, "But how much longer?"

"Well, studies have shown it has an overall survival rate of twelve months," Dr. Ventura answered. "I would say, however, it all depends on how your body reacts to the treatment and whether the melanoma has already metastasized to vital organs, such as the brain. But we need to act fast in order to guarantee the best possible results. You would get a total of four doses of Yervoy. Each dose would be given intravenously over a ninety-minute period, every three weeks. The full monthly cycle may cost around 90 million pesos [roughly US$40,000]." Then Dr. Ventura asked, "What insurance do you have?"

Antonio replied, "I'm enrolled in VIP prepaid insurance. I got their Gold Premium Service."

But switching to new treatments requires the doctor to order brain tomographies and new blood tests to check liver function, read journal articles, and interpret data in order for the treatment to be in sync with the biomedical time associated with the patient's melanoma. Only after careful evaluation of the current tumor's stage and the patient's bodily condition will the oncologist (in consultation with the patient) make the decision to prescribe Yervoy, order brain radiotherapy, or provide palliative care. Both doctor and patient would then need to weigh the toxic effects of the drug (fatal perforation of the intestines and serious liver and nerve problems, among other life-threatening conditions) against the survival rate and resulting "quality of life."

Immediately, Dr Ventura filled out hospital and insurance paperwork and ordered the corresponding exams. In less than seven days the results were available and emailed directly to the physician. The conclusions were somewhat hopeful: Antonio had no brain metastases, and his liver functions were normal. These results made him a good candidate for receiving the aggressive Yervoy treatment. His infusion session was immediately scheduled.

This case illustrates how the imagined time of biomedicine is actualized at the intersection of a private hospital and prepaid insurance. The synchronicity of cancer and treatment requires a synchronicity of payments as well. Antonio accessed medical treatments and drugs in an expeditious way, without experiencing deferrals in service provision. The prescribed drugs and treatments were conveniently authorized over the phone; Antonio did not have to stand in line or wait at the insurance office. Since his biopsy was conducted early in the course of the disease, the surgeon was able to remove the entirety of the mole. Later, however, during a periodic checkup, the oncologist came across suspicious symptoms of metastasis and ordered an MRI and then a PET scan for greater accuracy. After just a few days the report was conveniently emailed directly to Dr Ventura. Unfortunately, I was told, Antonio died three months later in the emergency room from cardiac arrest triggered by the aggressive metastases.

In my ethnographic conceptualization, timely interventions take place when the time of the insurance (business time) coincides with the imagined time of treatment; they are contemporary and thus coordinated. This coincidence allows for expeditious intervention, which seems to increase the chances for the patient to live longer. But this is not always the case. Neoliberal frameworks are not just pernicious for the poor. In Antonio's case, a huge expense was (rapidly) authorized for a treatment that seemed medically absurd: very little survival benefit and harsh side effects.

THERAPEUTIC DISJUNCTURES

Unlike Antonio, most low-income patients I met in Cali were unable to synchronize insurance, procurement of medications, access to clinical updates, and receipt of treatments and thus were unable to catch up with the disease. Given their location in the political economy of health care, patients like Pepe often entered into an arrhythmic relationship with biomedicine. In what follows, I illustrate the Kafkaesque moments in which doctors and patients experience the apparent mismatch of possibilities. I look at interventions that often expire before they are authorized by insurance companies, let alone provided.

To understand these, I use the concept of *therapeutic disjunctures*. As mentioned earlier, these are actions that take place without effecting change; because of their timing, they are inconsequential. A *disjunction* in a clinical context is an intervention that plays out arrhythmically and has not yet crossed from the medical imaginary to the local reality of public hospitals in Cali, Colombia.

Recall my friend Pepe. He was suffering from metastatic gastric cancer, and because of his insurance, he did not experience synchronicity. His medical encounters were not punctuated by coincidences between the medical time of tumors—as indicated by oncologic protocols and algorithms relating to stage and appropriate treatment—and the timing of insurance, related to the evaluation of the case and treatment, approval of expenditure, and approval of treatment. Suspense built in response to these therapeutic disjunctions, despite the hope instilled by Ley 100. In the context of this chapter, suspense becomes a practice wherein the law directs life and allows those who wish to endure bureaucratic vueltas to do so until, if they are lucky, they cross a threshold or, if unlucky, they die from either disease or exhaustion from chasing a solution.

This experience may be similar to what Povinelli (2012, 132) terms the "violence of enervation, the weakening of the will rather than the killing of a life." It is an experience that is simultaneously at an extreme and in a zone of ordinariness, where it is hard to distinguish modes of incoherence and habituation from conditions of structural violence (Farmer 1999) and social abandonment (Biehl 2004). Under these conditions, exhaustion prospers not in the context of traumatic events like military encounters and genocides but in quotidian life where terror becomes usual (Taussig 1992). This is the domain of life of the already dead, as Cazdyn (2012) would have put it, when access to medical services happens too late and medical plans fail to synchronize with bodies and tumors.[20]

These moments of exhaustion are eventful, yet discoordinated. Imagine a patient like Pepe, preparing for treatment, waiting for a round of cisplatin, and taking antiemetics to counteract the expected nausea even before he has an approved timeline for chemotherapy. The chemo protocol is not authorized because the requisite blood test has not been performed on time; chemo rounds are administered with half the prescribed dose. Medical interventions lag hopelessly behind their timely administration: symptoms and diagnoses follow a prescription and a prognosis, but they are not necessarily experienced in this order.

MOVEMENT WITHOUT MOTION

Dr. Masa and his encounter with Pepe was my inspiration for this final section. He is a senior oncologist who taught me about the nuances of cancer care and the complex ethical dilemmas doctors face in the neoliberalized health care system. I spent time with him in consultation rooms and at lunch meetings, breakfasts, social events, and congresses organized by pharmaceutical companies. From Monday through Friday, his schedule was hectic. He distributed his time between three to five different hospitals, where he would see approximately fifty patients per day. He would start at 7:00 a.m. and often finish around 7:00 p.m., sometimes even later. After twenty-five years of dedicated practice he became quite efficient at managing his fifteen-minute consultations, time when he would ask questions of and give answers to patients, palpate bodies, write prescriptions, give legal advice, and fill out forms.

During our first encounters, I asked him about chemotherapy and its relation to timing and rhythm. I wanted to know more about the sense of urgency that permeates oncology practice. The following vignette portrays how an oncologist explains cell biology to an anthropologist, by emphasizing the relevance of killing and time and the importance of strict adherence to the timeline set for treatments.

"For the sake of clarity and simplicity, imagine that the cycle of cellular division takes place approximately every twenty-one days. When you bombard the tumor with chemo you are aiming at baby cells, or cells that are undergoing division. If you keep administering chemo every twenty-one days, you will get to a point where only old cells remain. Imagine there is a room full of people, and you need to kill them all, but your weaponry is designed only to kill individuals who are young and unable to engage in sexual reproduction. After a few years you come back to this same room and kill those individuals who have now became adolescents. Later you come back for a third round and kill the remaining young individuals. At this point no reproduction will take place inside the room. You just wait until the remaining old individuals die. However, if for some reason you take too much time between killing rounds, the young individuals will continue growing stronger and reproducing themselves."

Dr. Masa continued, "But in Colombia, patients I work with get one round of chemo and we lose track of them. When they come back, their cancers have become more aggressive; they won't respond to the initially prescribed chemo regime. So when I get these patients I have to recalibrate dosages or look for a more aggressive option in the market. Not being able to follow strict chemo schedules makes a huge difference between someone who has a functional life and even lives longer and someone experiencing agony."

Dr. Masa does his best but feels constrained because of the way the national health care system has been configured. He explained to me, "As a doctor you would like to do more for your patients. In Colombia, however, the right to health and our medical practices are mediated by the insurance businesses' rhythms."

"Do you recall my patient Pepe?" he continued. "Well, he has invested all his scarce energies in doing futile vueltas. I have already told him to go before a judge and sue his insurance company. At this point there is no other option, unless he wants to keep waiting until his tumor turns into a purulent mass the size of a soccer ball."

Initially, Pepe consulted a general practitioner at the local clinic in Río Frio, a small town near Cali, about heaviness in his stomach and heartburn. As described in a copy of the clinical history he shared with me, in June 2011 generic omeprazole—used to treat reflux and peptic ulcer symptoms—was prescribed. Pepe recalled this time when his stomach cancer had not been yet diagnosed: "I was on omeprazole for at least three months, until the symptoms were unbearable, so I got really upset with the general practitioner. I told him my symptoms had not improved." His condition worsened. He lost his appetite. In September 2011, after fruitless attempts to control what appeared to be severe gastritis, Pepe was finally referred to a gastroenterologist at HUV in Cali.

Pepe's sister, who lives in Cali, scheduled an appointment on his behalf. However, because it was Christmas time there were no appointments available until mid-January 2012, four months after the initial referral. Finally, on January 15, the gastroenterologist examined Pepe, asked him to stop taking omeprazole, and ordered an endoscopy and a biopsy to understand what was happening in his stomach. He needed to confirm his suspicion of cancer.

On February 28, Pepe returned to see the gastroenterologist. The doctor skimmed the endoscopy images and the pathologist's interpretation until he found the diagnosis: Pepe had gastric cancer. The initial heartburn he reported to the general physician back in Río Frio had been caused by a tumor the size of a fist. The pathologist classified his lesion as *infiltrating*, which means it had already spread beyond the contours of the lesion, and *highly dedifferentiated*; that is, the cells were visibly different from the "normal" ones, highly malignant and aggressive.

I met Pepe for the first time during Dr. Masa's examinations at the outpatient oncology ward in mid-March 2012. Dr. Masa skimmed the entire macro- and microscopic description of the biopsy and looked for the diagnosis. "We need to downsize the tumor, which is located here [drawing a stomach on a sheet of paper], so it won't block the passage of food from your stomach into the intestines," he explained.

From this time on, Pepe's clinical history would display a big "High-Cost Patient" stamp on its front cover. He was officially a cancer patient, another patient whose disease had been diagnosed in a late stage, his experience defined not by diagnosis and treatment but by vueltas, perdedera de tiempo, frustration, and futility. Pepe prepared to receive full dosages of epirrubicin but became entangled in confusing bureaucratic processes. The generic capecitabine was difficult to get, and his EPS rejected his petition for the expensive drug Xeloda. He received partial cisplatin dosages that did not accord with the medical prescription, and epirrubicin was frequently out of stock. The treatment had to be suspended because an incomplete chemotherapy cocktail may inflict severe damage on bodies or render tumors resistant to drugs. The tumor grew. "If he does not get the drug soon, the tumor will come back with virulence and vengeance," said the doctor. Even though Pepe's clinical status was not "complete" and his treatments were partial, the insurance staff asked him to be patient. It takes "considerable time" to process chemotherapy authorizations, after all. Pepe talked to his doctors. His swollen abdomen was palpated by general practitioners, interns, oncologists, residents, students, gastroenterologists, and palliative care givers.

At the insurance office, Pepe handed the endoscopy and biopsy orders to the representative. He waited in line and became irritated. He yelled; his cheeks reddened; he felt dizzy and sat down on the sidewalk. Nothing happened. He had no idea when his treatment might continue. Pepe and his sister had undertaken all the required vueltas, and Pepe had had all the requisite tests and had prepared for chemotherapy. But he was caught up in vueltas. Indeterminacy opened up between the potentiality and actuality of treatments. Pepe took antiemetics in advance to prevent nausea, he stood in line at the pharmacy, he waited, and suspense built. The oncologist checked his blood test and looked at his creatinine levels. Forms, prescriptions, biopsies, hospital annexes, photocopies, signatures, seals, dates, and legible writing—all these elements had to cohere before the EPS reviewed his treatment application.

But the treatment was suspended. "How could we know if a chemo protocol has been effective when patients do not get their medications on time?" Dr. Masa asked. Since Pepe had not completed the number of prescribed infusions, his oncologist was not able to reclassify his cancer or choose a different protocol. According to standard oncology guidelines, prior to switching to a different treatment, patients must first receive several chemotherapy infusions in a row and then be reevaluated using the appropriate imaging technologies and laboratory tests. Dr. Masa explained, "I cannot switch Pepe from cisplatin to 5FU and then back to cisplatin. Patients need to get the whole protocol before moving on to a different one, especially if it is a second-line treatment." Dr. Masa suspected that the cancer had already metastasized: "Just by looking at his yellowish skin color and assessing his symptoms, I can tell Pepe's liver may have been affected."

Any surgical intervention at this point would have involved more risks than benefits for Pepe. Recall that in oncology, there is a sense of rhythmic calibration and time management but also expiration. For data to be considered *contemporary* with the prescribed chemotherapy, exams have to be carried out and interpreted at specific moments in the patient's therapeutic journey. Measurements and data about the tumor expire in a matter of weeks. Endoscopies, colonoscopies, and CAT scans provide information about the tumor size, its location, and its proximity to other tissues and organs, but this information is accurate only for short periods. Blood tests provide information about direct tumor markers (e.g., PSA, alkaline phosphatase) and indirect measures of bodily functions (e.g., lymphocytes and hemoglobin levels, creatinine). These are all particularly time-sensitive data.

But in Colombia, treatments for low-income patients often lose their curative potential and may prolong agony. Several patients I met in Cali were no longer able to swallow because their throats had been blocked with esophageal tumors. Many were disfigured by their disease and surgery; their veins were dyed and burned by the effects of chemotherapy. Some had catheters or tracheostomies or colostomies to manage. The majority of them were dying. Yet they were still expected to catch up with cancer and endure the disease and the delivery of treatments. They were *moving without actually moving*. They dwelled in a present that was already past while aiming at an impossible clinical future.

This does not mean that anticipating cancer through early screenings and clinical interventions and getting synchronized access to chemotherapy, for instance, would be the solution for these patients. There is plenty of evidence confirming that "speeding up" the pace of treatments for certain cancers, or being a few steps ahead of the disease, may also have detrimental effects and even shorten life (Temel, Greer, Muzikansky, et al. 2010; Esserman and Eggener 2023). Anticipating the development of the disease may not catch deadly tumors but rather slow-growing or precancerous lesions that, left alone, may not turn into a life-threatening condition (Welch 2006; Dumit 2012; Jain 2013).

By presenting the cases of Pepe and Antonio, I have sought to show that *speed, time*, and *distance* relate to each other in different ways, depending on the patient's position in the political economy of health care. Regardless of how fast Pepe strived to go, for instance, he was hardly able to move through his therapeutic journey; laboratory tests, drugs, insurance forms, and tumors were always out of sync. And that may be the definition of "going to die"; he seemed to move only toward death and only went somewhere at death.

The next chapter focuses on the judicialization of health care. It traces the bizarre legal mechanisms that have transformed the national health care crisis into a protracted and ordinary event. This crisis, I contend, has been fueled not only by health insurance companies' deferral practices, which impact cancer patients, hospitals, and health care staff, but also by the same writs (tutelas) created to protect patients' fundamental rights to health care and life.

2

Ordinary Crisis

Crisis. This was probably one of the most common words used by physicians and cancer patients when commenting about the current situation of the national health care system. Typically, this word refers to a time of difficulty or danger, an out-of-the-ordinary situation. In the context of medicine, it refers to the turning point of a disease when one must make a pivotal decision, indicating life or death. Dr. Artesano, a palliative care physician at HUV whose goal is to manage symptoms, usually at the end of life, likens a crisis to "an elephant in a cramped room; so obvious you couldn't ignore it, so awkward and bizarre you wouldn't get used to it."

"Let me be clearer," he said. "Think of pain. This is usually a visceral experience that may overwhelm us—physically, emotionally, mentally. In the case of most cancers, pain can be so intense that it can lead people to commit suicide. So my point is that pain—like the elephant in the cramped room—is nearly impossible to ignore. Most of us won't get used to it—unless it is well controlled, of course."

A crisis, hence, embodies a transformational event, an extraordinary moment when one must make a radical decision to change course. Yet it can also refer to a period of intense conflict that fails to reach a turning point.

In her *Anti-Crisis* manifesto, Janet Roitman (2013) has made a call to entertain crisis as a protracted and chronic condition, a bizarre yet ordinary situation. Consider the case of the Colombian health care system. Despite declaring bankruptcy, many public hospitals have figured out improvised and last-minute strategies to keep their doors open, albeit partially; while a number of EPSs have become insolvent and have been liquidated, new ones make it into the market as corporate mergers;[1] overworked physicians periodically protest on the streets because their salaries are not paid on time; low-income cancer patients wait, endure, and die as they seek medical care. Most of the public anger triggered by these events have unfolded as hopeful mobilizations that rapidly dissolve into routine and dull expressions of frustration. Crises go from unique moments with transformational potential to ordinary events.

Oscillations like these—between indignation, disinterest, and resignation—after all, are typical of capitalism. Karl Marx ([1894] 1981, 357) once wrote, "The crises are always but momentary and forcible solutions of the existing contradictions. They are violent eruptions which for a time restore the disturbed equilibrium." For David Harvey (1982), the contradictions inherent to capitalism are expressed in "violent paroxysms" on which are imposed momentary solutions. Drawing inspiration from these thinkers, I discuss how the effects of Ley 100 and its neoliberal restructuring are expressed in social discontent, inequity, and protests (often violent), which have triggered policy transformations that temporarily restore the perception of equilibrium. Instead of analyzing the national health care crisis as an ongoing transformation or a turning point, I propose to approach it as a deadlock that has endured for nearly thirty years. As such, crisis becomes an ordinary and chronic condition or, as Roitman (2013, 16) has put it, "a persistent state of ailment and demise."

"The worst part of the health care crisis," according to Dr. Artesano, "is that we have no idea whether the required changes will ever be implemented by the government . . . or whether these will have enough momentum to unleash meaningful transformations."

Although his words were spoken in 2012, they highlight the elusive nature of structural change in Colombia's recent history and offer a cautionary tale about the latest health care reform project filed in Congress in early 2023.[2]

"Every time there is potential for structural transformation, people get killed," Dr. Artesano told me. "There is a long list of social leaders, human rights activists and leftist politicians who have been assassinated because they represented a threat to the status quo. The case of the health care system is not the exception; hardly any of the laws and decrees promulgated over the years have resulted in meaningful changes. Rather, they have unleashed more social injustice, more death."

When I asked him about the seemingly perennial state of health care crisis, Dr. Artesano resorted to the Spanish phrase, "lo mismo de siempre" (same old, same old). Things are the same again after all. "Lo mismo de siempre" reflects the perception of moving toward a turning point, the building of momentum, and the simultaneous impossibility of reaching it. It signals a threshold, a decoupling of the link between action and reaction by which the latter fails to be in sync with the former. It refers to a state of *no change*, stasis.

Dr. Artesano used a military analogy: "Our health care system is like a time bomb without a detonator, ticking but not yet exploding." Surprised by his words, I immediately asked for clarification. The physician paused for a few seconds before continuing.

"Well," he said, "it's a time bomb because the system was originally designed to respond to market forces rather than the needs of patients. After Ley 100 was implemented, inequality skyrocketed, corruption is now a rampant practice, and the violation of constitutional rights has become quotidian. But these conditions have yet to trigger widespread social unrest that could eventually result in major policy transformations, especially for the poor.[3] Nothing has really happened as a result of this crisis, not even when patients die while waiting to be treated. We [Colombians] got used to living life defined by social *estratos* [strata].[4] We all complain, yes—we love complaining, but at the end of the day we get used to the same conditions we criticize. It's frustrating! Think about it. We want to change something that does not seem to be bothering us anymore.[5] Unless there is a radical transformation in how we think and care for each other, not much will be achieved; everything will remain *lo mismo de siempre*."

The crisis I write about highlights the simultaneous need for structural change and the seeming impossibility of actualizing it. Building on Derrida's *Aporias* (1993), I understand the Colombian health care crisis in terms of "a future advent which no longer has the form of the movement that consists in passing, traversing, or transitioning" (8). It is a moment in which the legal dispositions, clinical expectations, and health policy regulations are planned but rarely actualized (Greenhouse 2006). For the past three decades, low-income patients have dwelled at a threshold of anticipation, hoping to access treatments on time and live longer—*what ought to be* according to Ley 100—and the sudden frustration of not being able to access them—*what is actually possible*. In other words, while the national health care system has undergone multiple policy transformations, it has fallen short of materializing the reforms needed by the less wealthy.

In this chapter I explore how the bizarre becomes ordinary. I analyze the contradictory relationship between the insurance companies' practice of deferral, the rights to health and life, and the writ of tutela used to protect these fundamental rights. As discussed in chapter 1, deferrals are the EPSs' practices of defaulting on salary payments for health care staff or hospital fees and delaying the provision of prescribed treatments for patients. To counter these deferrals and access their prescribed medical services, patients suffering from high-cost conditions have been resorting to tutela. This is an anti-crisis mechanism created in 1991 for imparting neoliberal justice and protecting fundamental rights, such as life.[6] Filing a tutela is a simple and straightforward process. Patients can even file it on their own by downloading forms from the internet. Once a judge confirms that there has been a violation of a fundamental right, the tutela has immediate effects, and in no case can the period between the filing and the court ruling take more than ten working days.

While the tutela has allowed many Colombians to access medical services and protect their right to health, it has incentivized some high-cost patients to file it when their lives are threatened by waiting. At HUV, for instance, it was not uncommon to hear cancer patients suggesting they had better chances of getting a favorable tutela ruling once they prove their cancers have become metastatic or terminal. As I show, the anti-crisis mechanism of the tutela has played a double role; while it has been a boon, especially for low-income Colombians who have been typically neglected by the state, it creates perverse financial incentives that encourage them to wait and deteriorate and EPSs to continue delaying the provision of high-cost treatments.

CARE DEFERRED

Throughout most of my ethnographic research, HUV became my fieldwork headquarters.[7] Since it was founded in the 1930s, HUV has been a point of reference for working-class and poor Colombians living in the southwest. After the 1993 neoliberal reform, the hospital was transformed into an *empresa social del estado* (ESE), or state social enterprise. As a result, it is expected to deliver medical services directly or through contracts with individual providers and must compete for the preference of the purchasing organizations (EPSs). Hospitals like HUV "moved from a welfare-like system in which money was transferred directly from the state to a market competition model" (Abadía-Barrero 2022, 103). In this model, every medical service must be billed. And, of course, it becomes more preferable to sell specialists' services like oncology or cardiology than do primary care.[8] Selling more services—preferably high-cost ones—becomes the preferred business model for hospitals, while EPSs play the role of cost containment and financial vigilance, making sure health care funds are "responsibly" used and available to all Colombians who need them.

Like so many other public hospitals that were transformed into ESEs, HUV has struggled to maintain a permanent cash flow to fund its services and pay workers' salaries on time. In addition, management inefficiency and rampant corruption have been ubiquitous throughout most of this hospital's recent history.

I recall health care workers voicing their concerns about whether the next strike would finally force the hospital to close its doors for good. My main interlocutors on this topic were palliative care physicians. Led by Dr. Artesano, this group of doctors has been especially active in the hospital union for years, frequently standing behind the picket lines. During the longest stretch of my fieldwork (2011–13), they participated in the occupation of hospital aisles and administrative offices. According to Dr. Artesano, their motivation boils down to a set of perverse effects unleashed by the EPSs' late payments of salaries and hospital fees. He explained, "The hospital already owes me around nine million pesos![9] That's why I'm always trying to catch up in financial terms. But it's difficult. The hospital has no money. Most EPSs pay late and rarely disburse the total amount they owe us. Whenever we complain to the hospital management, we are told these businesses are taking sixty to ninety days to pay for our services; that we should be patient and continue showing up for work and holding consultations as if nothing has happened."

In Colombia, one of the main roles of the EPS is to connect the different actors in the health care market, the cogs in the machine—as Dr. Artesano would put it. These businesses are middlemen between patients and hospitals, physicians and patients.

"That is why we have taken over the hospital facilities," Dr. Artesano felt compelled to clarify. "We want to make sure our demands are heard by the local government, the EPSs, and the hospital administration. We have been systematically exploited."

Certainly, Dr. Artesano was fed up with the current financial situation. He was onboard with the union's plan to escalate its protest, even if that meant interrupting the provision of medical services to patients. He anticipated my questions about the repercussion of such actions: "They [referring to government officials and mainstream media] say that we should be held accountable for the hospital crisis; that the union is not allowing patients to access the oncology wards; that we are threatening their lives and violating their right to health care. These are all plain lies. Our fight is not against patients. It is against the whole *vagabundería criminal* [shameless criminal acts] that make a profit from physicians like ourselves and poor patients' health."

While protesters like Dr. Artesano were aware that blocking patients' access to hospital services went against their medical ethics, they were nonetheless willing to do so in order to gain leverage with the hospital management and become visible before the state. A couple of weeks later, during a critical escalation of the protest, a temporary solution was suddenly reached. The municipality stepped in and disbursed emergency funds to ameliorate the financial crisis. In exchange, Dr. Artesano and his fellow protesters agreed to vacate the premises. The hospital doors reopened, but nobody knew for how long.

Several EPSs still owed money to the hospital. When their debt becomes unmanageable, EPSs default on their payments. Then the government steps in to either inject funds or liquidate the struggling businesses.[10]

Barely two months after the municipality disbursed funds to prevent the crisis from escalating further, social discontent was again coming to the surface. "Pa'lante y pa'trás [Back and forth]," said Dr. Artesano "While many EPSs still owe us money, the government looks the other way and thinks our situation can be fixed with palliative approaches." "But palliation, by definition," he explained, "is a practice that cloaks and manages symptoms. It does not seek to cure or treat the disease itself."

Again, nurses and doctors found themselves standing behind picket lines, blocking Calle Quinta. This time, protesters carried wooden coffins on their shoulders to symbolize the death of the Colombian health care model. They shouted, "Health care is not a business! Save the public hospitals!" Protesters were especially upset because HUV was (once more) late paying their salaries.

This is what Dr. Artesano calls a delayed payment mind-set, or *mentalidad de pago atrasado*.[11] If insurance companies take too long to pay hospital fees, these institutions may start running out of cash and incurring debts with health care providers. Following Abel Castaño (2023), this is partly due to EPSs lack of incentives to engage in long-term investments, particularly in early detection or screening for high-cost conditions such as cancer. First, according to him, a focus on early detection and screening may end up triggering a cascade of overdiagnoses and unnecessary treatments for slow-growing tumors that may never represent an actual threat to patients. Second, EPSs would not want to "invest" heavily in primary care and screening to prevent large claims in the future, largely because enrollees typically switch EPSs over time. Why would these businesses want to invest in people whose "good health" might end up benefiting direct competitors? And third, EPSs' inability to engage in long-term goals is exacerbated when they are faced with financial difficulties and contractual requirements, such as paying providers' salaries.

According to Dr. Artesano, the consultations he holds today are often translated into the salary EPSs will pay him over the next two to three months. "The problem is that most of us live paycheck to paycheck," he said.

Failing to pay physicians' salaries on time turns into a form of debt (and theft). Yet EPSs are not necessarily penalized for doing so. After all, an important number of EPSs—especially those in the subsidized regime—have found that the only way to stay competitive in the market is by delaying payments to hospitals and the provision of high-cost medical services.[12] In so doing, these businesses engage in the financial market and redirect resources to less risky investments (see Graeber 2014).[13] As Marx ([1867] 1992) showed, the transformation of money to commodity to money (represented as M-C-M) would make no sense to capital unless that transformation was in fact M-C-M′, where M′ > M. Unless there is a constant potential for money returned through commodity exchange to be greater than money advanced, money is not capital. In other words, the EPSs' money derived from circulation in the health care system must be greater than the money initially advanced to it (as UPC, for instance). And the most feasible route to do so—under the current health care model—is by delays in treatment provision.

Although some EPSs have made noticeable efforts to provide the best care possible for their enrollees, most insurance companies that I came across at HUV had resorted to creating money from debt, enabling capital to reproduce itself in a realm of pure promise and waiting (Marx 1992), that is, pledging to provide health care to all Colombians and pay health care workers' salaries on time. For Melinda Cooper (2008), these practices may be understood as the "accumulation of biological futures." This concept, she explains, includes business models in the life sciences that are based on financial speculation and debt creation—venture capital funding, stock markets, and so forth.

In response to these conditions, nurses and physicians at HUV frequently find themselves on strike, blocking the main hospital entrance and marching on the street while medical appointments are canceled or postponed. When the government finally intervenes, hospitals have turned into a sort of financial black hole, a highly dense localization of financial need capable of engulfing any funds orbiting its vicinity. In the meantime, patients sue the hospital and/or their EPSs, arguing that their right to health has been violated because physicians are not available to see them. In what follows, I discuss the intersections of health care that have transformed these incarnations of crisis into ordinary becomings.

NO FIGHT, NO HEALTH

The crisis of the Colombian health care system cannot be explained exclusively in terms of lack of technology or financial resources.[14] Instead, the situation may be the result of liberalization policies. As described elsewhere in this book,[15] while the state disburses large amounts of public funds to provide care for all Colombians, the same state forgoes control of the financial inner workings of health insurance companies. Consider the following ethnographic examples:

In her book *Markets of Sorrow* (2013), Vincanne Adams discusses the painstakingly slow rescue and reconstruction efforts in the aftermath of Hurricane Katrina. She unveils the effects of "privatizing the most basic social services and the failure of these services to respond to [North] Americans in need because they are tied to market forces guided by profit" (1). As a result, she argues, "the recovery that should have taken a few years was turned into what locals call a funeral that would not end" (5). That is, post-Katrina became a stalled crisis that failed to reach a turning point. This "funeral that would not end" highlights capitalism's underlying tendency toward crisis and instability (Marx 1981).

Anthropologist Karen Ho provides another example. In *Liquidated* (2009), she has described this tendency for crisis during a period known as one of the greatest economic booms in the history of the US, the 1990s–2000. During this time, she writes, "the economy experienced not only record corporate profits and the longest rising stock market ever, but also record downsizings" (1–2). Ho analyzes how investment bankers juggled the relationship between massive downsizing and the production of a market crisis, which led to an increase in business value and the liquidation of Wall Street itself.

Likewise, in the context of Colombia, low-income cancer patients, bankrupt public hospitals, and metastasized tumors may turn out to be highly profitable after all—especially when neoliberal reforms get intertwined with the constitutional mandate to protect the rights to life and health. In fact, EPSs' systematic deferral—and the bodily deterioration that comes with it—has been paradoxically reinforced by the tutela, the anti-crisis mechanism created to protect citizens' rights to health and life.

Patients I met in Cali considered the tutela an especially effective mechanism when diseases were terminal or metastatic (El Espectador 2013). Under such conditions, thus, the state reemerges as a central figure in the management of patients' bodies. Therefore, the expected separation between market and state under neoliberal conditions—as Dan Mains (2012) has noted for places like Ethiopia—may not always seem to be perceived as such by its citizens.

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"Look!" shouted a woman at the oncology waiting room. "Look at the doctors and nurses who are protesting outside." Eager to see people's reactions, she turned around and said, "These folks know that the hospital management will only pay their salaries if they block the entrance to the outpatient facility."

Several patients stood up and walked toward the window. They wanted to see for themselves the unfolding protest.

The woman continued, "Health care workers are fighting for their paychecks, just as we [patients] file tutelas to protect our right to health. ¡Así le toca al pobre! [This is what the poor must do]. Even if I die, I will do everything I can to make them pay. I have the right to do so."

Her words reverberated around the waiting room. She had been able to tap into patients' widespread frustration and harness its potential. Few individuals had remained indifferent to her speech. There was a loud murmur interwoven with slurs against the government and EPSs. "That's right. ¡Sin tropel no hay salud, carajo! [No fight, no health, damn!]," responded a man who was standing next to her by the window. "We will have these *sinvergüenzas* [thugs] pay what they promised but never delivered."

In Spanish, *tropel* means "crowd," typically a chaotic throng. This word is often used to highlight mass mobilizations against social, political, or economic injustices, which often turn into violent clashes between protesters and the security forces of the state. In addition to experiences of tropel, many of the patients in the waiting room were dealing with the uncertainties of a partially closed hospital. Nobody knew whether physicians would show up for consultations that day—the same consultations they had fought to schedule for so long.

The atmosphere in the waiting room was especially tense that day. It felt as if any incautious interaction or loose comment would ignite a tropel inside the room. Nurses were not spared. "Hey, miss, I have an appointment today, not tomorrow," a patient complained. "You better make sure a doctor sees me today, okay?" the patient uttered bitterly.

Overwhelmed by these kinds of reactions, the nurse replied in a cracking voice, "Look, I am sympathetic with you all. But you must be patient. There is a rally going on outside! I am not willing to tolerate *groseria* [bad manners] and shouting. If you really want to complain and get things done, go to a courthouse and file a *bendita* [blessed] tutela. What else do you expect me to do?"

Over the years, the tutela has become a popular mechanism used by Colombians to channel social discontent and access treatments and medications (Ambito Jurídico 2012). In 2018, for instance, there were around 200,000 tutelas filed to protect the right to health, most of which were directed against EPSs and hospitals (Defensoría del Pueblo 2018). According to Abadía-Barrero (2015a, 63), "Insurers argue that their refusal to provide these services conforms to the law, while patients use the same law to gain access to services denied." Lack of accountability becomes quotidian.

As an anti-crisis mechanism, the tutela was created to confront the violation of fundamental rights, yet it has the potential for becoming an extension of the same problems it seeks to counter. "To a great extent," mused Dr. Artesano, "the overreliance on tutelas may explain why certain patients do not access medical services when they are still curable. Waiting to get worse may pay off in the long run—or so they think. But waiting is a risky strategy. When they eventually get a favorable court ruling, their bodies have often deteriorated due to a lack of timely treatment."

"How's that?" I asked.

"For many of my patients, for instance, it doesn't really matter if tutelas grant them access to medical services that won't ever cure them. What really matters to them," he emphasized, "is seeking justice against some of the most visible faces of the health care system—like hospitals, EPSs, the government. Patients want to make sure they get what they are entitled to. They have been repeatedly promised health care, so they have decided to claim it."

Dr. Artesano's words point to a phenomenon I frequently came across at HUV: low-income cancer patients were trading their chances to be cured in the present for the possibility of exercising their rights in the future—when their bodies are too sick and deteriorated for most oncological interventions. Under this logic, becoming visible before the state and making sure it fulfills its promises is worth the bodily decay, an irrational decision from the point of view of biomedicine and economics. Thus the point of care for many of these patients is not cure, as my colleague Misha Klein made me realize, but having the rare opportunity to become visible before the state.

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Here I turn to Alonso, a stage III laryngeal cancer patient I met during my visit to one of the EPS offices located near HUV. Due to his rapid physical deterioration, his wife, Luz, had been doing all the hospital and insurance paperwork on his behalf. After several months of caring for her husband, she became an expert in navigating the health insurance bureaucracy. On weekdays the couple would wake up at 3:30 a.m. and get to the hospital by 5:00 a.m., just to be told the oncologist's planner was full. "It's a disrespect with patients," Luz complained. "We show up at the hospital hoping for some sort of miracle," she said, while making the sign of the cross on her chest.

Today, against all odds, Alonso and Luz managed to get a same-day appointment. Waking up early and skipping meals to pay taxi fares had finally paid off.

"I persevered. I stood by the nurse at the front desk and never moved an inch from her," Luz explained to me. "At some point the nurse told me that someone else had missed their scheduled appointment. So we got assigned their spot. That's how we managed to see the oncologist the same day. But don't be fooled. Our real goal is to file a tutela. That's why we are here today."

When I ran into the couple at the insurance office, they were standing in a long serpentine line that did not seem to be moving anywhere. The office was packed, as usual. When I looked toward the front of the room, hoping to get a sense of how long they would be waiting, I realized there was only one representative behind the customer service desk, just one person in charge of processing all these patients' paperwork.

"Esto va para largo [This will take a long time]," I said to them.

Frustrated, Alonso stepped out of the queue and sat down on a plastic stool. I took his place in line, next to Luz, who began telling me about Alonso's journey with cancer. When I mentioned I was conducting research to understand how patients manage to access their medical services via EPSs, Alonso waved his hands at me. He grabbed a cloth from his pocket and placed it at the base of his neck, just inside the tracheotomy opening. He then carefully dried the excess saliva coming out of it and fitted a white plastic ring inside the opening to prevent the still fleshy tissue from blocking his airway. In an aspirated voice, he asked, "So you want to learn about my medical history, right? Look at these documents." He carefully bent forward and grabbed a black plastic bag from underneath his plastic stool. "This is where we keep my medical history and the evidence that would allow us to prove that my right to health has been violated."

After two requests and a legal petition, insurance representatives had told Alonso that his prescribed Erbitux would not be provided. "When the moment comes, my wife will use these documents to file a tutela on my behalf. If we cannot get medical service *por las buenas* [the nice way], we will get it *por las malas* [the tough way]," he asserted.

Alonso had reached a tipping point in his frustrating relationship with the EPS. His fight would soon be moving away from the hospital and health insurance office into the judiciary system, where a judge will review his case and decide whether the EPS has threatened his right to health and life.

To file a tutela aimed at protecting the right to health, patients must include detailed medical insurance evidence to support their requests. Most of the time, patients are expected to provide a document that is furnished by EPSs themselves, which "has been standardized as a Service Denial Form" (Abadía-Barrero 2015a, 68). This is an official document that confirms the status of the request made by patients and details the reasons for denying or delaying the provision of a treatment.

While Alonso was attempting to discuss his clinical history with me, Luz interjected, "Indeed, we are pursuing legal actions as soon as the insurance representative provides us with the letter."

"The letter?" I asked.

"Yes, the Service Denial Form," she replied. "I am confident the judge will take this document as solid evidence that my husband's right to health has been threatened. The insurance company will then have to cover all his future treatments and drugs, regardless of costs."

This intersection of medical and legal practices is known as the "judicialization of health care," a term that refers to a "transfer of decision-making power from the Executive and Legislative to judges and courts" (Gonçalves and Machado 2010, 39). For patients like Alonso, getting access to high-cost cancer drugs is possible if they have previously wasted time with the EPS bureaucracy and, most importantly, demonstrated that their bodies are incurable because of the wait.

Physicians also play a role in this increasingly frequent practice. Their expertise often is infused with legal parlance and advice during their fifteen-minute consultations. While doctors talk about exams, feel lumps, and disinfect purulent tumors, they also spend time advising patients about tutelas. "I encourage my patients to file tutelas," said Dr. Artesano. How else are they supposed to access their treatments? Even though some of them may be terminal, I often feel relieved when they get a favorable court ruling. It feels like a form of revenge, you know, against an unjust system. And it gives me some peace of mind. Besides, favorable tutelas may even allow oncologists to prescribe cutting-edge drugs on the market that would have been impossible to access otherwise."[16]

What are the ethical implications of protecting a fundamental right when it has already been violated? How do patients make sense of the right to health and their deteriorated biologies in neoliberal Colombia?

(IM)POSSIBLE RIGHTS

Rights are commonly understood as inalienable conditions that confer inherent protections and privileges on recipients. In "Who Is the Subject of the Rights of Man?" (2004), however, Rancière argues that human rights are often applicable when individuals can demonstrate they are being deprived of those rights. His work puts together a relation of inclusion and a relation of exclusion. Similarly, access to health care in Colombia is inscribed in conditions in which rights are presented as a function of deservedness versus finances. This understanding has been fueled by "disagreements around the idea of justice in terms of how much social harm is morally acceptable when granting people's individual petitions" (Abadía-Barrero 2015a, 75). In the case of cancer patients I worked with, prompt access to medical services often became a reality when their right to health had been systematically violated and their life threatened as a result, that is, when patients could demonstrate they were deprived of the rights they have.

Hoping to illustrate how low-income patients in Colombia may often find perverse incentives to waste time, Dr. Artesano sought to activate the power of imagination: "Picture a bullet-proof vest. This piece of military equipment is used to protect people from getting injured or killed by gunfire. In the context of Colombia, however, this imaginary vest tends to stop bullets after bodies have been previously shot at. Only then the vest magically becomes bullet-proof—protecting its user from future shots. But what's the point of wearing a bullet-proof vest if it only protects you after your body has been injured?" he questioned. "This is how our health care system works."

Dr. Artesano's words highlight the bizarre relationship between tutelas and the right to health I frequently encountered during fieldwork. The cases I witnessed at HUV suggest that tutelas tended to be especially effective after diseased bodies were "wounded" by the bullets of inequality, time, and burdensome bureaucracy. This is when a right becomes inalienable.

Miriam Ticktin (2006) has examined a similar phenomenon in which biological deterioration becomes an asset. In her fieldwork with undocumented immigrants in Paris, she showed how these individuals were relying on physical injuries or HIV infections to claim the basic "rights" supposedly granted to "human beings." Ticktin saw this phenomenon as an "ethical configuration in which people trade in biological integrity for political recognition" (33). The state renders sick bodies visible (over laboring bodies)—as long as they remain sick from life-threatening pathologies. This phenomenon is based on engaging other people in relationships of empathy and in this way demonstrating their common humanity; this is an ethics that, when taken to the extreme, following Ticktin, entails selling one's suffering, bartering for membership with one's life and body. "Although driven by the ethical imperative of relieving suffering" (34), she writes, this form of humanitarianism may have discriminatory and violent consequences.

In the case of cancer care in Colombia, letting bodies deteriorate makes possible the disbursement of public funds into the health care circuit, allowing cutting-edge (often high-cost) chemotherapy regimens and low-income conditions to cohabit in the body. This means that EPSs may leave small tumors untreated until they grow and metastasize. While the state does not question the legitimacy of EPSs' treatments and payment deferrals, it intervenes legally to grant low-income cancer patients their right to health when their bodies and tumors are necrotic.

BACK AT THE EPS OFFICE

The following vignette illustrates how a tutela ruling granted Alonso access to Erbitux but also transferred the EPS' financial risks associated with his large claim back to the neoliberal state.

"We should be getting called any time soon," mused Luz, Alonso's wife.

"Called soon? When?" Alonso replied in exasperation, while placing a finger on his tracheotomy. "We should probably go back home," he shrugged.

"If you leave, we will accomplish nothing. We have expected the most, we can expect the least. Please hang on," urged his wife, visibly upset.

Not much time had passed when an insurance representative gestured, asking them to step forward. The couple had finally made it to the customer service desk—arguably their final destination.

The representative greeted them with a smile. I call her Amparo. "What can I do for you today?"

"My husband [pointing at Alonso] has cancer. He has been requesting his Erbitux for more than two months."

Luz opened the black plastic bag and grabbed a bunch of documents held together by an elastic band. She wetted her index finger with saliva and quickly skimmed through the numerous documents, until she came across a small wrinkled paper. She carefully unfolded it and placed it on Amparo's desk.

"Take a look at my husband's Erbitux prescription," she said. "It turns out his application was denied twice by this EPS. So it's time for us to file a tutela. We are here to request the official rejection letter from you."

The EPS representative took her glasses off and looked at the prescription. She then turned to the computer and typed Alonso's last name into the database.

There was a prolonged silence.

Amparo mused, "I wish I could help you get the much-needed drug, but unfortunately it does not seem our EPS will authorize it anytime soon. It is considered expensive. I mean, it is expensive if we compare it to generic bioequivalents like cetuximab, which can be as effective as Erbitux."

"Yes, I get that," said Luz. "But what else are we supposed to do? We come here and get told the physician should prescribe something different. We go to see the physician, and then he tells us Erbitux is the only option—which you guys should provide." "Who should I listen to?" Luz said, raising her voice.

Visibly irritated, she uttered words that sounded more like a warning than a mere plea: "Please pay attention to what I am going to say. My husband has a metastatic cancer. Is this clear enough for you?" "We have to move forward with a tutela," she told her.

Amparo answered, "I completely understand. And I am here to help. Let me look for the denial form."

Amparo turned back to the computer screen. She checked Alonso's full name against his cédula and reentered it in the database. "I will need to consult something with my supervisor. Would you mind giving me a moment?" she asked. Luz and Alonso nodded.

Only a few minutes had passed when she was back at her desk. This time she was holding a white envelope with a document inside. "Here you have it, the official letter. It explains why your treatment wasn't approved. It has the EPS's seal stamped at the bottom. Please keep it in a safe place and attach it to your tutela paperwork. This [pointing at the document] is the most important piece of evidence for your writ. As soon as you get a favorable court ruling [she crossed her fingers], come back to our office. We should then be able to coordinate the delivery of the drug to the HUV oncology department."

Given the severity of his cancer, Luz was confident the judge would rule in Alonso's favor and override the EPS decision. Arguably, the incurable cancer had given him the edge he needed.

And Luz was right. The judge who reviewed the tutela request took less than six days to arrive at a favorable ruling, and Alonso's EPS was forced to provide the prescribed medication. Two months later, Alonso died at home, next to his wife, when his body could not take it anymore. Alonso's case shows how financial resources and legal mechanisms are usually activated in situations of bodily crises—not before. Alonso's medico-bureaucratic journey illustrated how the tutela becomes an ordinary mechanism that ends up reproducing and sustaining crisis itself.

OUTSOURCING OF ETHICAL LIABILITY AND FINANCIAL RISK

Alonso's legal determination came with a catch. The same court ruling that sought to protect him against the EPS's inaction, released this business from the financial costs associated to his Erbitux claim. Even though EPSs are usually presented as the main "targets of complaints", a ruling against them authorizes these companies to access public funds (Abadía-Barrero 2015a).

This financial twist was rendered possible through a mechanism known as *recobro*, "recovery" or "reimbursement."[17] Until 2020, *recobro* was a financial request by which EPSs charged previously uncovered medical care to the Fondo de Solidaridad y Garantía del Sistema General de Seguridad (FOSYGA).[18] Over time, recobro became a popular mechanism by which EPSs transferred their financial accountability back to the government, which highlights the fusion of the welfare state and the corporation (Lamphere 2005; Adams 2013).

To analyze the financial twist rendered possible through recobro, I now turn to a conversation I had with Amparo, the same EPS representative who met with Alonso and Luz. Two days later, when I returned to the EPS office, I asked her whether she wouldn't mind chatting with me as part of my research. This time our conversation would take place at a small restaurant next door.

While having coffee, I asked her, "I am curious about your meeting with Alonso, the cancer patient who has a tracheotomy and requested the treatment denial form. His visit to the EPS office puzzled me. And I apologize if I misunderstood what really happened that day, but his visit was not about requesting access to treatments. He was exclusively interested in collecting the EPS documents needed to file a tutela against your EPS, which the insurance provided swiftly. How common it is for patients to request these denial letters and for representatives to advise patients on filing a tutela against the same EPS they work for?"

Amparo took a sip of hot coffee and shook her head. "It is rather common. From time to time, I do encourage patients to sue us." She took another sip. "Most of us do it. It does not mean we are betraying our company or doing unethical stuff. In fact, I would say, this is a quotidian part of our job. While we help patients access medical services, we also seek to ensure our company stays financially fit. The tutela allows us to do both things at the same time."

I asked, "Could you elaborate on how a tutela, which is commonly filed against an EPS, suddenly becomes favorable—even desirable—for these businesses?"

"Well, it all starts with something called a reinsurance policy. This is a policy we get from another insurance company. It allows the EPS to be protected against large claims. Let's say my company buys a policy and insures treatments that go beyond 15 million pesos per patient. In other words, we have a deductible of 15 million per patient. Any claim beyond this amount would automatically be covered by our reinsurance policy. But it does not mean we should go beyond the deductible every time someone files a high-cost claim. Doing so has the potential to increase our premiums in the long run."

Amparo explained that reinsurers handle risks that are usually too large for EPSs to handle on their own. These companies help EPSs get protected from the risk of a major claim event, that is, from cancer patients like Alonso who require expensive chemotherapy. This is a form of outsourcing that imbues health insurance practices with a ghostly attribute and makes it more difficult to know who is taking seemingly unethical decisions in the health care system.

Sergio Sismondo has written about this ghostly phenomenon in the context of pharmaceutical marketing in the US. In *Ghost-Managed Medicine* (2018, 9), he argues that "the work to coordinate the production and circulation of knowledge is performed by invisible hands." These invisible hands represent middlemen or middle managers who work backstage. They are either invisible or look as though they are doing something else. As ghosts, "we can't quite see them, or can't see them for what they are" (14). The visible ones, on the other hand, may truly believe their jobs are helping patients. Pharma representatives and key opinion leaders (KOLs), for instance, are generally fully committed to what they are doing. And they do it "for the sake of patients," Sismondo writes. This makes it difficult to identify who is unethical.

In Colombia, ghostly practices are incarnated in the reinsurance policies EPSs purchase from other insurance companies. These policies have allowed many EPSs to outsource ethics to a point where no one is seen as unethical, where EPSs representatives themselves can actually "help" and guide patients through legal suits against their own company.

There was, however, another piece of the puzzle I was missing.

"I wonder about the seeming incompatibility between tutelas and reinsurance policies," I said to Amparo. "After all, when a judge rules in favor of a claimant, the EPS is forced to provide the medications it was sued for. Could you please explain how EPSs manage the associated costs? Wouldn't these companies pass these costs on to their enrollees?"

"Not necessarily," she replied. "Remember that health care is a right in Colombia. All Colombians, regardless of their capacity to pay, should be able to access medical services. So passing these costs on to patients, especially the less wealthy, would be problematic. The costs associated with larger claims must be passed somewhere else."

"Where?"

"To the government. The government chips in through FOSYGA. That is how we can provide universal health care without increasing our premiums and still be competitive on the market."

To make her point clearer, Amparo resorted to the following example: "Do you know something about the corn industry in the US?"

"That corn is everywhere," I said. "It is a cheap ingredient used in most processed foods."

"For sure. That's because corn production is highly subsidized by the gringo government. As far as I know, this subsidy allows farmers to stay competitive in the market. It allows them to sell their corn at incredibly low prices—way below the costs of production. Similarly, EPSs in Colombia stay competitive, partly thanks to recobro. Think of it as a form of government subsidy that allows us to provide universal health care while making a profit—even when there are huge financial risks associated with large claims from catastrophic diseases."

Her words made me realize that the ethical responsibilities taken away from the welfare state in 1993 were being transferred back to it via the tutela. This was a seeming paradox: the tutela does not only seek to protect fundamental rights such as health (ensuring patients access to their prescribed treatments and drugs); it also, and crucially, seeks to safeguard insurers' capital by transferring part of their financial burden to the state and outsourcing their ethical responsibility to reinsurance companies.

This is the corporate-state fusion common to neoliberalism. In her ethnography about post-Katrina New Orleans, Adams (2013) has shown how the two entered a new form of relationship: capitalism making money on the welfare state. She described the phenomenon in which the same agents that produce disasters often manage to capitalize on the aftermath of such calamities. In Colombia, the anti-crisis mechanism of the tutela allows EPSs to apply for recobro and further capitalize on their failure to provide prompt care to all patients.

The Colombian health care system is an example of a ghostly market-driven, publicly funded bureaucratic failure. This trickle-down effect may have occurred in two ways: first, by the growth of EPSs that find ways to provide health care for low-income and working populations while also making profits; and second, by desperate and exhausted patients (and their families) "who must resort to the judiciary to avail themselves of their constitutional right to health care" (Abadía-Barrero 2015a, 63).

. . .

In this chapter I discussed how the national health care crisis has become a stubbornly protracted event fueled by EPSs' deferral practices and their relationship with anti-crisis mechanisms such as the tutela, which has often encouraged low-income cancer patients to let their bodies deteriorate. These patients are often caught between a simultaneous impossibility of getting cured and the possibility of accessing virtually unrestricted and immediate medical care—the same care that was so elusive prior to a favorable tutela ruling. The relationships I described between the tutela and EPS treatment deferrals seem to have created the financial incentives that transformed the health care crisis into a chronic condition, a disaster that never ends.

In chapter 3 I offer a contrast with the previous two chapters. There I discuss the health insurance regime for the wealthier population. The chapter teases out the ontological indeterminacy of cancer and its relationship to high-end hospitals and a patient who could, albeit not without effort, pay for the treatment. I analyze how dermatologists, pathologists, and oncologists studied a patient's skin biopsy and enacted two seemingly contradictory diagnoses: a lethal melanoma and a benign dysplastic nevus, commonly known as mole. Because their differences under the microscope or through dermatological goggles may be subtle, physicians often disagree on what they see.

3

Malignant yet Benign

"Be careful, *parce* [friend]. Getting screened for cancer in Colombia may cause cancer, especially if your patients are rich!"

This is how my friend Sebastian, a janitor who works at a private hospital, reacted when I told him that my partner, Juana, had just been diagnosed with two seemingly incompatible skin conditions: a melanoma and dysplastic nevus.[1] While the former is known for being an aggressive (often lethal) form of skin cancer, the latter is an unusual-looking and benign mole that may (or may not) turn into a melanoma. Because their differences under the microscope or through dermatology goggles are subtle, physicians often disagree on what they see. When medical services are not unrelated to the patients' ability to pay for them, what emerges through a microscope might be different. This chapter focuses on the ontological indeterminacy of cancer and its relationship to two high-end hospitals and a patient who can, albeit with effort, pay for treatment. How do medical practices, notions of "best care," and ways of seeing shape how diagnoses are enacted in Colombia? What does it mean that cancer and its absence can coexist in the same tissue?

Building on Sebastian's words and Juana's therapeutic journey, I analyze the direct relationship between medical ontological (dis)agreements, social class, and the chances for diagnosing cancer. Unlike those of the low-income cancer patients I followed, Juana's story emerges at the intersection of two private clinics and health insurance companies for wealthier patients. To discuss her journey I build on STS scholarship, which highlights that statements about realities and the making of those realities are practiced together (see Latour and Woolgar 1986; Mol 2002; Law 2004; Barad 2007; Myers 2015). Observing skin tissue under the microscope, for instance, allowed physicians to do something that was not "out there" and therefore shaped what they saw. Their ways of seeing and examining Juana's body allowed for the co-occurrence of cancer and its absence. Thus, I write about *how* physicians saw was not unrelated to *what* they saw and therefore to their practices of medicine in neoliberal Colombia.

My intent is not to criticize physicians but rather to discuss how the 1993 neoliberal reform made certain diseases more easily recognizable than others. Nearly thirty years after the neoliberal reform, Colombia has become one of the most unequal countries in the region, making for an extremely classed practice of medicine (Hernández 2002; Ewig and Hernández 2009). An oncologist at a private hospital in Cali told me, "Poor patients who suffer from high-cost diseases usually waste time and endure burdensome bureaucracy. Prepaid patients, on the other hand, get boutique service."

"Boutique service?" I asked.

"Yes. This is how we refer to the medical services provided to prepaid patients at high-end hospitals. They get assigned health care concierges who assist them to quickly reach their doctor of choice, get same-day appointments, and fill out burdensome insurance paperwork. Because they rarely have to deal with insurance representatives and bureaucracy, these patients are able to speed up the pace of their own medical services."

"This means that wealthier patients who suffer from cancer have better chances of getting cured, right?"

"Not necessarily." He then elaborated: "Attempting to do more screenings and prevention campaigns is not always translated into fewer cancer deaths. Waking up earlier does not mean the sunrise will take place sooner."

His words not only illustrate the clinical uncertainty permeating the treatment of cancer in Colombia and elsewhere but also the perverse effects of coupling biomedicine and capital.[2] My friend Sebastian has experienced the consequences of this relationship. On the one hand, he has mopped floors and cleaned sinks and toilets at private hospitals for over ten years and also listened and talked to prepaid insurance patients while performing his job. As an individual who is enrolled in health insurance for low-income Colombians (EPS), on the other hand, he has struggled with the medico-bureaucracy whenever he seeks access to medical services at public hospitals. He is well aware of EPSs' most common practices to reduce costs: prescribing cheaper drugs, and perhaps drugs of lower quality, and deferring access to expensive treatments such as chemotherapy until patients are often too weak to receive them (see chapter 1).

By contrast, prepaid patients tend to access uninterrupted medical services and leapfrog the bureaucratic lines of EPSs. However, cutting in line may often push patients to overrun the time of their own biology—that is, the time it takes for cancerous cells to grow and the time it takes a body to respond. In the case of Juana, for instance, speeding up the pace of her care prompted doctors to disagree on what they saw under the microscope. In less than one month, several dermatologists, pathologists, oncologists, and surgeons had reviewed her skin biopsy; palpated her scalp, neck, and armpits to examine lymph nodes; taken measurements of her forehead; and planned for aggressive intervention. Right after scheduling the surgery to excise her lesion, however, Juana chose to slow the pace of her care and sought a second opinion. A new and different diagnosis followed: dysplastic nevus. How can it be that a cancer *is not* anymore?

Despite the seemingly good news, however, the probability that she had a melanoma on her forehead had already been introduced to her. Just as with a two-sided coin, Juana's final diagnosis could only land on one side or the other—not on both. But since her melanoma and dysplastic nevus had similar chances of occurring, both were probable. Thus, uncertainty mounted. If the odds of having either condition should be taken seriously, wouldn't it make sense to play it safe and prioritize the cancer diagnosis before it is too late? Isn't cancer care about immediate action and anticipation? Sometimes yes, sometimes no.

Instead of framing my discussion as an either/or diagnostic dilemma or misdiagnosis (Jain 2013), I write about the simultaneity of a melanoma *and* a dysplastic nevus. Here I draw inspiration from Marisol de la Cadena and Strathern's *Partial Connections* (1991). In her work *Earth Beings* (2015), de la Cadena discusses how certain beings such as Runakuna and Tirakuna can be human and nonhuman—but not only.[3] She explains that this state exists simultaneously; humanness and nonhumanness cannot be disentangled.. In Juana's case, melanoma and dysplastic nevus are technically cancer and noncancer, respectively—but not only. They emerge simultaneously in the same skin sample and in partial connection to each other.

In the Euro-American world, where things tend to either be or not, this simultaneity tends to become "phantomatic," a term I borrow from Astrid Shrader (2010). She relates "phantomatic ontology" to Derrida's (1994) notion of hauntology, "which describes the paradoxical existence of a phantom as neither being nor non-being, neither present nor absent, neither of the 'past' nor of the 'future,' but which affirms an indeterminate relationship between being and becoming and between 'past' and 'future'" (Shrader 2010, 278). According to her reading of Derrida, phantoms cannot be understood as being different and separate possibilities, where each happens independently from the other and at one particular moment in time. Rather, phantoms can be concurrent, simultaneous occurrences. That is, phantoms may represent more than one object occupying the same space-time. In her piece, for instance, she uses "phantomatic" to refer to a marine dinoflagellate organism commonly known as Dino, which could be fish killers, a benign cyst, or a unicellular amoeba. Dinos emerge from sediments, collectively attack fish, and disappear from the water columns as soon as most of their fish prey are dead. These organisms' phantomic character is characterized not only by their hide-and-seek behavior but also by the their ephemeral appearances and disappearances and the very nature of their species. Their multifaceted ontology reacts to temporal configurations and environmental conditions.

Drawing inspiration from the life of this organism, I seek to understand my partner's diagnoses as phantomatic too—as cancer but not only. The differences between her diagnoses are neither epistemological, considering different perspectives on the same object, nor ontological, in the sense that multiple realities coexist at the same time (Mol 2002). Rather, I argue, differences here concern the (im)probability of being cancerous.

With the neoliberalized health care system and the prepaid insurance regime as the background, I start by describing how this (im)probability is shaped by the ways in which doctors use their own bodies, hands, and eyes to recognize *what* they see under the microscope. Next I show how my double relationship with Juana—as fieldwork interlocutor and partner—played a crucial role in her diagnoses. Because I had already spent several months observing the Kafkaesque absurdities of the health insurance for the poor—its bureaucracy and inefficiency—I insisted she enroll in one of the different prepaid insurance plans available. I did not want her to waste time and be seen who-knows-when by who-knows-who. Thus, I introduced her to a dermatologist I had met during my fieldwork.

My double role as ethnographer of cancer and partner would take Juana into multiple examination rooms, where different physicians doing "good" shaped the phantomatic character of her diagnoses. I conclude this chapter by discussing the ethical tensions that emerge when health care providers and caregivers in Colombia enact what is considered the "best good" in the context of prepaid insurance (see also Kleinman 2006; Mattingly 2014).

A MELANOMA PROSPECT

When I first asked Juana about her reasons for visiting a dermatologist, she explained, "Physicians often ask me to monitor my moles and keep track of changes in color, size, or form. It turns out I am at risk for developing skin cancer." Juana's skin type, after all, aligns with the most common risk criteria highlighted in dermatology literature. First, she is blonde and light-skinned. Second, when growing up on the Caribbean coast she was exposed to direct sunlight for prolonged periods. And third, there is a history of skin cancer in her family.

She then pointed to her scalp and said, "This is what I am talking about. And since you are conducting your research at hospitals, I thought you might know a good dermatologist!"

"What a coincidence," I replied enthusiastically. "I have just started following Dr. Rayo as part of my fieldwork. He is a senior dermato-pathologist and the director of a private hospital lab. Why don't you get an appointment with him? He works with prepaid insurance and seems well known in his field."

I grabbed my wallet and looked for his business card. "Call his secretary. Tell her that you are my partner and that you want to schedule an appointment with him. A *palanca* won't hurt," I confidently said. The English translation of *palanca* is "lever," a simple machine consisting of a bar that pivots on a fulcrum and is used to transmit torque. In Colombian Spanish, the word *palanca* is commonly used to refer to situations in which social ties transmit "torque," for instance, help individuals get a job interview, "cut the line" to access a public service, get a transit fine waiver, or get an appointment with a renowned physician whose examination schedule is usually full.

Juana dialed, and I listened to the conversation.

"I would like to schedule an appointment with the doctor." The nurse (who is also a secretary) asked, "What is your type of insurance? ¿Viene por EPS o por prepagada? [Are you coming as an EPS or a prepaid insurance patient?]." These questions were intended to redirect my partner to the corresponding examination planner. "I am a prepaid patient and will be paying in cash," she replied. Because Dr. Masa is outside the primary network of providers, Juana would have to pay out of pocket for her consultation and then wait between thirty and sixty days to get reimbursed by her insurance.

Juana's case reminds me of how middle- and upper-class women in certain Latin American countries, such as Ecuador, tend to avoid public hospitals, especially to deliver a baby, opting for a costly C section at private clinics (Roberts 2012). Unlike these women, my partner's main reason for choosing a prepaid insurance was *time*. She was earning a modest salary as a preschool teacher, but she was willing to pay extra to expedite the process and get same-day appointments and access treatments "on time."

"By the way," Juana added, "I am Camilo Sanz's partner—the anthropologist who works with Dr. Rayo." The nurse said, "Oh, yes, Camilo, of course. Please send my regards to him. Now, let's see. [Long silence.] If you are a prepaid patient, the doctor may be able to see you tomorrow, Thursday, or the day after tomorrow. When do you prefer? It will be 130,000 pesos [US$65] for the consultation. Cash only."

NEXT DAY: DERMATOLOGY CHECKUP

Unlike most doctors in the EPS regime who must limit their consultations to fifteen minutes, Dr. Rayo was not in a hurry. After an ice-breaking conversation, the physician logged into his computer and opened a blank clinical history. "What can I do for you?" he asked. Juana grabbed her hair with both hands and uncovered the two-inch mole that extended from scalp to forehead. "I am concerned about this mole," she said.

"Could you sit down on the trolley?" the doctor asked, while putting on magnifying glasses and zooming in on her skin. He palpated the mole and rubbed his index finger against it, as if trying to feel its contour, its texture. There was silence in the office. Dr. Rayo engaged his body in his work, assuming different postures: he stepped back and forth and looked at the mole from different angles and distances; he tilted his head slightly to the left, then slightly to the right. The way this physician used his body reminds me of Natasha Myers's *Rendering Life Molecular*

(2015), in which she shows the role played by body movements in crystallographers' protein representations at a lab. Clinicians I followed must also cultivate bodily dexterity in order to render visible and recognize skin and cellular structures. Recognition, as I understand it, is about mapping anatomical knowledge learned from a book or dissection corpse, for instance, onto a living body (Park 2006; Saunders 2008; Prentice 2013).

Finally, the physician took a deep breath. While exhaling he uttered, "Have you noticed other similar moles on your body? "I don't think so," she replied. The doctor palpated her scalp, turning her hair all around. Then he palpated the facial area next to her ears, where the jaw articulates with the skull. The physician performed circular movements with his index fingers. Then he repeated the same procedure on the back of her head and around her neck. He was looking for suspicious ganglions.[4]

Dr. Rayo said, "I don't want to alarm you, but we have to conduct a biopsy of your mole ASAP." He was warning Juana about the urgency of the situation. He took another deep breath followed by a short exhalation. "It looks like malignant tissue."

"What do you mean?" Juana asked, with evident anxiety.

"There are high chances it's a form of cancer," the doctor replied.

There was silence in the office. He then made eye contact with me and said, "Camilo, you might find this interesting for your research."

This whole situation took me by surprise. I must admit I had difficulty thinking about my research at this moment, let alone following Juana and her "aggressive cancer." I had been interacting with cancer patients for several months, seeking to understand how oncology is practiced at hospitals in Cali. But it never occurred to me that I would end up following my partner as she was diagnosed with the same disease I was studying. I was simply not prepared for it. Yet I also knew I had to pay attention to the doctor's words. I was, after all, Juana's partner—but not only.

The doctor asked me, "Why don't you get closer and take a peek at her lesion?"

I stood up and walked toward the trolley. Juana stared at me as if waiting for some sort of comforting gesture. I grabbed her hand firmly, yet continued listening to the doctor's instructions.

"Use your naked eyes first," said the doctor. "You will see there is an intense black tone; this is a bad sign. Now look at its size. Moles bigger than five millimeters should be considered very suspicious, and hers is definitely bigger than that! Take a look at its form and contour. It's totally irregular and has multiple indentations, right? It's asymmetrical. Unlike benign lesions, it does not have a circular shape or homogeneous color." Dr. Rayo was following dermatological classification guidelines, such as the ABCDE,[5] which provide physicians with standardized diagnostic criteria. It teaches them how to recognize possible cancers.

Since I have no medical training, the doctor not only had to teach me how to use my body but also how to interpret the ABCDE diagnostic guidelines in order to recognize cancer. Seeing is crucial. Yet seeing should not be solely understood as an image-centered activity, but as a learning process that involves hands, repetitive movements, body postures, and questions (Prentice 2013; Halpern 2015; Myers 2015).

In trying to master this process, I recall Bruno Latour's (2004) essay on learning to recognize different smells in the perfume industry. Latour describes how trainees become a "nose," that is, someone able to discriminate subtle odor differences and tell them apart even when they are masked by or mixed with other odors. Before the teaching session, Latour writes, "odors rained on the pupils without making them act, without making them speak, without rendering them attentive, without arousing them in precise ways: any group of odors would have produced the same general undifferentiated effect or affect on the pupil" (207). Each of these trainees viscerally learned to be affected by seemingly unidentifiable differences through the mediation of the kit.

Similar to the trainees' experiences, I was learning to be sensitive, affected, moved, put in motion by the mediation of instruments and their relations with moles. I put on the dermatology goggles and looked at her skin. "Can you see its structure?" Dr. Rayo asked me. I must admit I wasn't able to see anything at all. This was my first time using dermatology goggles. "I can only see blurred images, dark shades," I replied. He grabbed my arm impatiently and pulled me over. "You need to come closer, closer. Can you see it now?" "Only a blackish spot, though," I responded with frustration. "Can you see the internal structure? Look at the skin, the pores." After assuming different postures and coordinating them with Dr. Rayo's instructions, the mole suddenly "appeared" before my eyes. It had different tonalities of brown and black. There were pores, indeed, some sort of black filaments all over and lines randomly intersecting one another. Crucially, the mole was not "out there" waiting for me to discover it. It emerged through a coordinated effort of eyes, body, and hands.

Once the improvised teaching session was over, he said to Juana with a sense of urgency, "Talk to my assistant and schedule a biopsy appointment. Moles that have an orderly crisscrossing structure are usually benign, but yours has no symmetry whatsoever."

The study of what medicine discovers about bodies cannot be separated from the way we look at them. The act of "looking" requires the observer to formulate questions and assess preliminary data and probabilities (Juana's family history and skin type, visual features of the mole, etc.) in order to hypothesize about diagnoses. When I asked pathologists about the diagnostic protocols that help them identify cancer in their daily practice, their explanations often boiled down to the importance of knowing how to see and formulate the right questions.

By "right questions," I mean the hypothesis-driven modes of inquiry that test probable answers in controlled experiments. When formulated, these questions are expected to match tentative answers. In other words, specific ways of seeing set the conditions for different ways of arranging biostatistical data and probabilities and produce different diagnoses and interpretations (Bowker and Star 2000; Saunders 2008; Roberts and Sanz 2018). Scientific representation, after all, hinges on modes of intervention, Ian Hacking (1983) notes. For example, one cannot simply look under the microscope and see cellular patterns. A microscopist must intervene directly in the optical system by applying dyes, for instance. And the image changes as the microscopist manipulates the material on the slide. Thus, the rules and practices of a given methodology serve not only to describe but also to *enact* the reality that they seek to understand (Mol 2002; Law 2004).

Yet medical practice, ways of seeing and asking questions, are not the only elements that enact a diagnosis. Juana's prepaid insurance also paved the way for her melanoma. By reducing the bureaucratic procedures and waiting times, for instance, prepaid patients like her get prompt access to treatments and drugs and more tests, which lead to answers and new series of tests. This acceleration may encourage doctors to prefer certain diagnoses over others—or to come across cellular structures that look like cancer (Welch 2006). Thus, the ethics of "playing it safe" becomes a common rationale at this intersection of high-end hospitals and prepaid insurance regimes. It shapes how physicians "see" biopsies and ask questions. Juana's case shows that there is no separation between clinical facts and socioeconomic status, on the one hand, and ways of seeing, on the other. These seemingly different domains of practice emerge together as doctors cared for Juana and observed her skin tissue under microscopes and through goggles.

THE FIRST BIOPSY

As Dr. Rayo cut through the skin, blood flowed down Juana's eyebrows. Gently he grabbed gauze and dried it. Using a pincer, the doctor took a tiny skin sample and placed it inside a small glass container filled with alcohol. The surgical wound was then closed with three stitches, and the skin tissue was sent to his pathology laboratory for microscopic examination.

For the medical world in general, pathology is a subfield that studies and provides diagnoses through examination of whole bodies or surgically removed organs and tissues. In the latter case, pathologists who specialize in cancer observe the tissue's cellular pattern under the microscope and determine whether it is malignant. To do so, they typically follow cell morphology criteria. In other words, pathologists compare what they see under the microscope with biomedical descriptions of normalcy. As Gilbert Welch explains in his book *Should I Get Tested for Cancer?* (2006), the likelihood of cells being cancerous increases when they deviate from these descriptions. Furthermore, cells that exhibit a greater variation in size and shape are more prone to be cancerous. And the higher the number of these cells undergoing division, the greater the chances they are cancer. Pathology is, after all, considered the gold standard for providing cancer diagnoses. It is expected to *black box* cancer. Drawing on Latour (1987), a black box represents knowledge or categories that have become stable. A black box, hence, transforms a cloud of data and mere probabilities into facts—the basis for future theories. In a similar way, pathologists black box data and preliminary observations, setting the basis for future treatments and prognosis too.

A week later, Juana and I returned to Dr. Rayo's office. Dr. Rayo sat down and explained the diagnosis to us: "It wasn't easy to come to a final decision; we had several disagreements along the way. Half of my colleagues thought your lesion is merely a dysplastic nevus. The other half, however, prefer to see it as a melanoma."

The physician paused for a few seconds.

"Let me clarify my point. Given your family history and your skin type, I think it's better to play it safe and go with the cancer diagnosis. It's always advisable to think about the future and prepare for the worst-case scenario. The good news, however, is that we haven't found conclusive evidence to confirm a metastasis, yet we still need to conduct further studies. I will refer you to a surgeon oncologist, who can excise your lesion and assess whether your lymphatic nodules have been compromised."

The doctor paused for a moment. Disconcerted, Juana and I looked at each other.

"I am aware you might need time to digest the news," the physician went on to say. "But we should move forward with the plan. A prompt intervention guarantees a much better prognosis."

Dr. Rayo and colleagues had agreed that the tissue's cellular structure looked atypical under the microscope. However, there was a "tie" between physicians who cast their votes in favor of a melanoma and those who did so for a dysplastic nevus; each condition had a similar occurrence probability, and both were more or less equally possible. Yet how could cancer and noncancer coexist in the same tissue? Doctors would need to pick just one option.

Under conditions of uncertainty, pathologists often need extra confidence to "tip the diagnostic balance." In his article "Making Moves in a Cardiac ICU" (2020b), Scott Stonington uses "tipping the balance" to describe the process by which physicians reach a state of self-confidence that allows them to make initial moves at a busy hospital. This state of self-confidence, he observes, is often reached by considering any new information that has become available. In the case of Juana, this information is represented by her type of insurance, light skin, and family history of skin cancer. It allowed pathologists to feel confident about tipping the diagnostic balance. Dr. Rayo, the senior pathologist, would be the person in charge of tipping the balance. He would treat the lesion as if it was a melanoma—as if it was cancer.

This is the moment when the creation of equivalences or similitudes acquires a central role in my argument and in Juana's story. In *The Order of Things* (1994), Foucault introduces sympathy as one of the four "similitudes" that shaped the logics of representation in the classical period. According to him, sympathy "has the dangerous power of *assimilating*, of rendering things identical to one another, of mingling them, of causing their individuality to disappear—and thus of rendering them foreign to what they were before" (26). Sympathy transforms and creates. In Juana's case, for instance, assimilating a dysplastic nevus with a melanoma transformed her "atypical" cellular structures into malignant ones. By rendering them equivalent, Dr. Rayo pledged to play it safe and exported the atypical cells into the terrain of cancer. According to this logic, if a mole looks like a melanoma, then it must be cancer and should be treated like cancer. The clinical protocol for treating an early-stage skin melanoma tends to be clearly defined: conduct biopsy; excise tumor, including tissue beyond its margins; scrape bone; check for the nearest ganglions and excise. In this context, doctors, who do not want to be held responsible for failing to prevent a death, prefer to tip the balance toward cancer and be cautious, to err on the safe side.

In the prepaid insurance world, however, this rationale encourages preventive testing for particular cancers, and there is often a strong incentive to overdiagnose. Some of these efforts are undoubtedly motivated by the best intentions (see Jain 2013), believing that testing for early cancer is in the patient's best interest rather than waiting until it is too late. Recall that melanomas are often asymptomatic until they metastasize. When in doubt, therefore, treating a suspicious mole *like* a melanoma makes sense in terms of biomedicine's goal to cure patients or extend their lives (Kaufman 2005).

Dr. Rayo typed a referral note for the surgeon and attached a copy of the biopsy report.

> *Diagnosis: Melanoma.*
> *Consider doing a radical excision of entire lesion.*
> *Extension studies needed to confirm possible metastasis.*

The physician erred emotionally on the diagnosis, the medical fact. He knew that a sense of urgency, and anticipation, needed to be instilled in Juana. And because her melanoma would require a rather large-scale intervention, she was immediately referred to a surgeon oncologist.

Wouldn't worrying too much about what may matter in the future distract doctors from what matters now?

THE SURGEON ONCOLOGIST (SAME DAY, AFTERNOON)

Using goggles, the doctor looked at the melanoma and, with a ruler, took measurements. His job as a surgeon would be to choose the most radical yet least disfiguring surgical procedure possible. The focus of medical attention had now officially shifted into the realm of cancer. After all, her diagnosis had been successfully black boxed. At this point physicians would rarely look back. Black boxed categories become so accepted that they become invisible, and only pop into focus again when an outsider questions them (Bowker and Star 2000).[6]

"Have you noticed changes in your eating habits? Any nausea or sudden weight loss? Is there anything in particular you want to share with me?" asked the surgeon.

"Not really," Juana replied.

"Could you please move your head down? I will check your posterior ganglions." The surgeon palpated her neck, then the area between her jaw and ears.

"Could you stand up?" He palpated her armpits and breasts. "I just want to make sure there are no ganglions or suspicious lumps anywhere in your body."

He then explained his plan. "I would excise the whole lesion, and include a margin of 1 centimeter beyond its contour. If the dimensions of the lesion are currently 2.5/1.5 centimeter, I will need to cut almost a centimeter beyond them. The incision might end up being approximately 3.5/2.5 centimeters. And I would also have to scrape the bone tissue itself to make sure no traces of melanoma are left behind. Then, depending on the biopsy report, we would know for sure whether you are a good candidate for ganglionic emptying."

The doctor grabbed a sheet of paper and provided Juana with what looked like a quote. "Let's see. For excising a melanoma like yours I usually charge 1,500,000 pesos [US$750] plus 600,000 [US$300] for my anesthesiologist and 400,000 [US$200] for my assistant. In total, everything adds up to 2,500,000 [US$1,250]. Needless to say, this amount does not include the hospital fees and supplies." Because Juana would pay out of pocket, she needed to get an accurate quote of all the costs involved. The care of explaining the surgery to her goes with the care of explaining the cost. Melanomas, skin measurements, and ganglions emerge together with hospital fees, anthropologists' palancas, physicians' honorariums, and insurance reimbursement policies.

The surgeon grabbed another sheet of paper and sketched something that looked like a facial silhouette—Juana's face. He used it to explain the surgical procedure.

"Excising your melanoma would leave a large scar on your forehead." He then colored an upper area in his drawing. "I would need to pull as much skin as possible from your forehead and your scalp in order to close the wound and put some stitches. The problem is that there is not much skin I can pull without disfiguring the left part of your face. If I pull skin from your forehead, your left eyebrow would inevitably move up, and your eyelids too. And you wouldn't be able to close your left eye for several months until the skin regains elasticity." Using his finger, the physician pointed to Juana's scalp. "Pulling skin from the scalp is even harder." There was a deep silence in the office. Juana and I were staring at the physician's drawing.

He continued, "I need to be assisted by a plastic surgeon during the procedure." He stood up and grabbed Juana's forehead. "The plastic surgeon would pull here, take a bit from down there, push on this side, and move your scalp a bit, if necessary. Do you see what I mean?"

This sort of professional collaboration is feasible in the world of private insurance. As long as Juana can pay out of pocket and is willing to discuss her finances with physicians, there are virtually no obstacles between her skin lesion and physicians' scalpels, and no waiting in line or wasting time with the insurance bureaucracy. By contrast, the insurance companies for the working class and poor would rarely authorize such intervention. Plastic surgery, after all, is often considered an ancillary and luxurious medical procedure.

THE PLASTIC SURGEON

The clinical focus now shifted from the realm of cancer into the world of aesthetics. "I can definitely do it," said the surgeon. "However, I would need to get a flap of skin from your thighs or buttocks to cover the hole after the excision is done. I guarantee the scar will heal nicely, though," he added.

Apart from the technicalities of the procedure, a detailed account of the financial costs was required. "How much would that procedure cost?" Juana asked, yet immediately felt compelled to clarify her question: "I am asking because I have a reimbursement policy. I would pay in cash for the surgical procedure and then wait until my insurance pays me back." "Okay, I see," the physician said, while opening a drawer. He grabbed a sheet of paper and did some math calculations. "Just working on your forehead, I charge 2,500,000 [US$1,250], and my anesthesiologist's rate is 700,000 [US$350]. That means the total cost for the plastic surgery would be 3,200,000 [US$1,600], without including hospital fees and materials."

This simultaneous care of explaining the money and treating her body had now reached a tipping point for Juana. Only fifteen days had passed since we first visited Dr. Rayo, yet four more doctors had rapidly joined: one oncologist, two dermatologists, and one plastic surgeon.

The more tests required and the larger the number of doctors who became enrolled in her case, the higher the chances for disagreements and for recognizing diagnoses that may seem to cancel each other out. I must acknowledge the role I played in her diagnosis and how my own plan for accelerating the pace of medical services had pushed Juana into a confusing whirlpool of anticipation and multiple physicians doing "good." Her interaction with the insurance company was limited to a few phone calls and emails during these hectic weeks. Her biopsies and examinations were conveniently authorized over the phone; Juana had no need to stand in line or wait at the insurance office—unlike the majority of Colombians (Abadía and Oviedo 2009). What would she do? In what follows I describe the physicians' different ethical grounds that allowed her melanoma and benign mole to become phantomatic diagnoses.

DYSPLASTIC NEVUS: A SECOND DIAGNOSIS, A SECOND PALANCA

Juana had decided to seek advice from a cousin, who happens to be a renowned rheumatologist in the country. Her cousin reacted with surprise after listening to her convoluted story and introduced her to a different group of dermatologists and pathologists at Valle del Lili hospital, another private medical setting. It was clear to him that a second look at her skin would be necessary before moving any further with the medical plans. The following is a short excerpt from that conversation.

“First of all, please calm down,” said Juana’s cousin. “Was it really necessary to visit all these doctors in such a short period? In medicine, I believe, it is important to keep things as simple as possible, especially when our health care system has been designed to follow the money, not the patients. You have to stop this chaotic chain reaction and get a second opinion about your lesion ASAP! You need a physician who has not been involved in your case, an outsider, a doctor who can see things from a different perspective. Here’s the phone number of a dermatologist I know personally. Her name is Dr. Prudencia. Tell her that we are cousins.”

Juana felt optimistic. She was being guided by someone who is not only a medical expert but also a close relative. This relationship became a palanca because it would allow her to immediately connect to a different group of physicians. Doctors like to help other doctors, after all, especially when they know each other and have worked together in the past. As a result, new relationships with dermatologists, pathologists, and the time of treatments were being established, which would be less defined by money and health insurance reimbursement policies than by family ties and professional links of trust.[7]

The appointment with Dr. Prudencia was scheduled in no time. The day of her visit, Juana brought a complete copy of the clinical history, exams, and plans for intervention. The physician, however, did not bother looking at any of these. “If a second opinion is needed I won’t really need to get bogged down with the details. Rather, I would need to start from scratch and send the tissue to our lab.”

The dermatologist immediately focused her attention on Juana’s forehead. Without using magnifying goggles, she looked at it, rubbed her index finger against it, and, after a long silence, shared some preliminary thoughts.

“At first sight it does not look like a melanoma. To make sure, however, we need a biopsy. Then we will go from there. Are you okay if I take another sample of tissue right now?” asked Dr. Prudencia.

At this point, her question sounded like a mere formality. We all knew what needed to be done. After all, Juana was really hoping her skin would get a second chance.

"Yes, please do so," Juana replied.

"Great. Could you please sit down on the trolley?" Dr. Prudencia put on dermatological goggles and latex gloves. "I will clean the area and inject some local anesthetic before excising a small chunk of your lesion."

Taking a second skin sample from her forehead took a few minutes. When he was finished,[8] Dr. Prudencia said with evident enthusiasm, "The roots of the mole seemed quite superficial, and that's a great sign. But let's wait for the biopsy report. If pathologists conclude the skin sample is merely a benign lesion, you wouldn't need further treatment. If, on the contrary, the melanoma diagnosis gets confirmed, I would just reopen the wound, widen the surgical area and excise any cancerous tissue that may have been left behind. But I wouldn't need a plastic surgeon to do that!"

Dr. Prudencia had chosen to give Juana's forehead the benefit of the doubt and revise the initial diagnosis. By doing so, she would avoid the trap of "diagnostic anchoring," that is, "believing one's own or someone else's prior diagnosis too strongly and thus failing to re-write the past as new information becomes available" (Stonington 2020b, 14–15).

This act of revision could also be understood in terms of Stengers's Idiot (2005a). The figure of the Idiot represents someone who resists the consensual way in which a particular situation is presented. In clinical encounters and phantomatic diagnoses like the ones described in this chapter, the Idiot would demand that we slow the pace of medical care, "that we don't consider ourselves authorized to believe we possess the meaning of what we know" (Stengers 2005a, 995). Thus, Dr. Prudencia set loose previous clinical definitions, allowing other possibilities—other ontologies—to exist.

She placed the skin tissue inside a small glass container and sent it to the pathology lab downstairs. This time I followed behind. The sample was a black chunk of skin, the size of a kidney bean, with traces of pink flesh and blood. My partner's name was written on it: "Mrs. Juana; September 10, 2012." Next to it there was a brief description of the sample: "Skin tissue taken from forehead and scalp." On separate hospital letterhead the dermatologist attached the following request for pathologists: "Assess and compare melanoma vs. dysplastic nevus." This particular request, as explained earlier, was intended to guide or "move" physicians' cognitive process, assisting them in narrowing down the field of diagnostic possibilities and making them attentive to specific cellular structures and not others (Prentice 2013).

A technician placed the container on a plastic tray, along with other samples. "Are you Camilo?" she asked. I nodded. "Please follow me." After last-minute phone calls to the lab manager and multiple explanations about my research, I had finally managed to get access to the lab where pathologists would study my partner's skin tissue.

"Please put these on," the technician said, handing me a pair of latex gloves and a surgical mask. She scanned the labels attached to each of the containers on the tray and distributed them to the different units in the lab.

Juana's mole was being taken to the histopathology unit, where solid tissues removed from bodies are studied at the microscopic level. There the container was once again scanned and immediately assigned a numerical code. An hour later and according to lab protocols, it was taken out of the container by a different technician and sliced thinly, placed on slides, and stained with dyes before it could be examined by pathologists. I sat on a metal bench and waited two more hours.

Finally, I greeted the senior pathologist, who introduced me to three of his students and one dermatology resident. Following our brief introductions, they immediately gathered around the microscope and zoomed in to Juana's tissue. I was about to observe both the construction of facts and new scientists (Traweek 1992; Myers 2015). After each of the students had taken several turns looking through the microscope, they sketched their observations on sheets of paper. The senior pathologist silently observed. Meanwhile I leaned toward the table and saw geometric figures of some sort. The following is a short excerpt of their conversation.

Student 1: "There is surely a pronounced dysplasia. The structure is indeed atypical."

Resident: "See the cytological architecture? There is an isolated proliferation of melanocytes. They are located somewhere here [points with his finger] in the nest, next to the basal area. Some cells have scarce cytoplasm. But they are quite large."

Student 2: "How big?"

Resident: "Large enough. They may even have elongated hyper chromatic nuclei. At first sight you won't see this elongation, though. You need to look carefully."

The senior pathologist pulled over a metal stool and sat down. He looked through the microscope, observed one of the drawings, and immediately commented, "This representation shows a high degree of atypia. Don't forget that there is also a lamellar fibroplasia close to the papillary dermis."

After a considerably longer discussion, the senior pathologist knew it was time to make a decision based on the two diagnostic possibilities provided by Dr. Prudencia.

"Should we classify this lesion as a melanoma or dysplastic nevus?"

Student 1: "I have the strong feeling this specimen is merely a dysplastic nevus."

The senior pathologist responded, "But tell us why you wouldn't consider it a melanoma."

Student 1: "Even though there is a high degree of dysplasia, the type of cellular architecture does not entirely match what you would expect to see in a melanoma."

"Is that all?" the senior pathologist asked with evident impatience. "We have already talked about the cellular architecture, right? What have we learned about rapidly growing cells like the ones you may find in melanomas?"

Student 3: "That they may quickly spread beyond their initial site."

Senior pathologist: "That is right. It means you need to pay close attention to the margins. Now take a look under the microscope. Zoom out a bit, if necessary! Can you see? Can you find evidence of atypia beyond its margins?" He immediately answered his own question: "Not at all! The neighboring tissue looks quite normal."

In this teaching interaction, both the senior pathologist and the resident were training the students in proper ways of reasoning and seeing so they would be able to "recognize" cancer under the microscope. The senior doctor had them look several times at the sample and sketch the structures they saw. Graphic renderings and repetitions are often crucial for this type of learning. And it is through a repetitive sequence of observations, bodily postures, sketchings, and discussions that a particular cellular architecture came to be recognized and effected by pathologists.

The senior pathologist typed in the computer: "Dysplastic nevus, thoroughly exscinded."[9] A revised diagnosis had now been provided, and according to it, Juana would not require further treatment; the cells once labeled "cancerous" were now being considered "normal"—yet atypical-looking. This new diagnosis, however, seemed to be in stark opposition to the melanoma enacted by Dr. Rayo. Juana and I were confused. The doctors were having difficulties labeling what they saw under the microscope. Whom should Juana follow? In cancer there is not always a clear answer; it all depends. Despite the seeming differences, Dr. Rayo and Dr. Prudencia were both sincerely concerned about my partner and did their best to care for her. Their notions of "good care," however, were not homogeneous. Being a "good" doctor, after all, is not a static matter (Kleinman 2006). What does it mean for Colombian physicians to "do good" in the context of cancer and prepaid insurance?

• • •

I conclude this chapter with a brief discussion about the ethical pluralism that emerges when health care providers and caregivers enact what they consider the "best good" (Kleinman 2006; Mattingly 2014). In her book *Moral Laboratories*, Cheryl Mattingly writes about the daily life of children with cerebral palsy and their parents in Los Angeles. She describes how the parents often found themselves propelled into complex reasoning tasks shaped by ethical deliberations, evaluations, and experiments as they strived to create the best life possible for their children.

As parents move through nonhomogeneous spaces (schools, parks, churches, clinics, soccer fields), "they navigate multiple moral activities and authorities, including ones that clash with their own sense of a 'good life' for their children and for their families" (Mattingly 2014, 8). The decisions they may make at a school, for instance, may be in conflict with what they choose to do (or not) at a soccer field. Ethical pluralism, after all, is what characterizes ordinary life.

In the clinical context described in this chapter, ethical pluralism helps us analyze how two groups of physicians enacted phantomatic diagnoses. From the very beginning, Dr. Prudencia and Dr. Rayo had their own expectations about Juana's skin; each of them had their own understandings of "good care." Their ideas, therefore, shaped what was possible to see at examination rooms and under microscopes. When Dr. Prudencia sent Juana's tissue to the lab, for instance, a special note was attached to the container: "Assess melanoma vs. dysplastic nevus." A black box was being reopened. This note sought to narrow the diagnostic possibilities and guide pathologists' vision. Dr. Prudencia had been in charge of looking for an alternative to the melanoma diagnosis. Surprised by Juana's therapeutic journey, Dr. Prudencia accepted the challenge of seeing with fresh eyes. Her notion of "good care" was about questioning a diagnosis and slowing the pace of medical interventions. In this context, being a "good" doctor may be about "waiting and seeing," limiting aggressive and disfiguring interventions.

In the case of Dr. Rayo, however, his motivations for "seeing" and practicing medicine seemed to be informed by the drive to move faster and anticipate cancer. And he did not want to be held responsible for failing to act "on time." He constantly emphasized the importance of excising the alleged melanoma before it metastasized beyond Juana's forehead. Once it undergoes metastasis, he had explained, the chances for curing her would be nil. He was just being honest, though. And since he was playing the double role of dermatologist and pathologist, his own expectations about the melanoma were immediately transferred from the examination room into the biopsy report—black boxing his naked eye suspicions. This allowed him to "do good" by speeding up the pace of treatments, enrolling other physicians in the process, and choosing aggressive and invasive interventions to kill a growing cancer. In the context of cancers, sometimes it makes sense to excise several centimeters beyond the lesion's margins, scrape bone tissue, and even do a ganglionic emptying—just in case, just to play it safe.

In choosing to play it safe and diagnose a melanoma, prepaid insurance and boutique service allowed Dr. Rayo to bypass burdensome bureaucratic requirements and get immediate access to treatments and drugs. For doctors like him, being a good doctor could mean staying ahead and acting in the flow of time (see Stonington 2020b). Under these conditions, therefore, "doing good" becomes a matter of staying in motion and making decisions—even when clinicians must guess and speculate about the future. This ethical rationale in the context of cancer may often be translated as the need to look more to find more (Dumit 2012). Yet looking more thoroughly may increase the chances of disagreements and unnecessary interventions, allowing *what* emerges to be cancer but not only.

Ten years later after her incident, Juana remains as healthy as she was then and aligned with the conditions of possibility presented to her by the second biopsy and benign diagnosis. The multiple encounters with physicians at the intersection of a private hospital and prepaid health insurance (largely unleashed by the anthropologist who writes these lines), transformed her and the ways in which she would interact with destiny-making technologies like biopsies. As Alice Rivières (2021, 29) has noted regarding her testing for Huntington's disease, "Revelation does not inform you. Quite the contrary: it transforms you. It can either make you sick or make you better: it all depends on what you do with it."

With neoliberal medical reforms in my home country as background, this chapter sought to discuss the ontological indeterminacy of cancer and its relation to a patient who paid for the treatment—not without effort. Inspired by my friend Sebastian's words and my partner's therapeutic journey, I analyzed how medical practices and ways of seeing bodies entered into physicians' understandings of "doing good," the prepaid health insurance regime, socioeconomic conditions, and palancas. Thus, I wrote about how *how* physicians saw was not unrelated to *what* they saw and therefore to their practices of medicine in neoliberal Colombia.

In the next chapter, I return to HUV, where I conducted the bulk of my fieldwork, and focus on the pharmaceutical market for chemotherapy drugs. I discuss the ethical conundrums navigated by oncologists as they are caught between the mandate to prescribe generics, which often are scarce, and the abundance of branded, overpriced bioequivalents.

4

Branded Time

The prices of brand-name, or branded, medicines in Colombia often exceed what people in the US pay for them (Fajardo 2015), and the price differences between brand-names and generics are among the most significant in Latin America.[1] Yet the overpricing of branded drugs in Colombia is not what kept physicians up at night; the chronic scarcity of generics did.[2]

Dr. Masa helps me illustrate this point. As I explained earlier, he is a senior oncologist who mostly treats patients enrolled in EPSs for the poor or unemployed. In addition, he works part-time at several hospitals in Cali, alternating between the oncology wards at HUV and other smaller medical facilities owned by EPSs.[3]

Dr. Masa explained, "They [patients] are struggling to get generic anti-cancer drugs, the same medications that the Santos administration has pledged to make widely available for all. And, this is, of course, a serious problem! You see, generics are the kind of drugs we [physicians] are encouraged to prescribe. These drugs are covered by health care plans and included in the national formulary, largely because they are far less expensive than their branded counterparts. But these are often scarce. So let me be blunt. Sometimes [the problem] is because drugs are expensive, other times because they are affordable [Unas veces es porque las drogas son caras, otras veces porque son baratas]. What kind of game are we playing? [¿A que estamos jugando?]."

Dr. Masa and his fellow oncologists are often caught between affordable anti-cancer generics—which seem to promise so much for a politics of universal health care "precisely because they circulate beyond or outside the patent" (Hayden 2007, 475)—and newer and expensive branded drugs that promise a life without cancer or, at the very least, a life with manageable cancer.[4]

In 2012, Dr. Masa and colleagues at the National Institute of Cancer (Instituto Nacional de Cancerología) filed a petition at the Ministry of Health. They demanded the national government guarantee the supply of "essential" anti-cancer drugs—typically generics. In the doctors' view, the scarcity of these drugs reflects undue government attention to the interests of the multinational pharmaceuticals.

Dr. Masa explained further: "Increasing the supply of anti-cancer generics should not be this difficult. We are not requesting something that hasn't been invented. The drugs are already there. Most of them have been around for more than fifty years and are inexpensive—trust me. The problem is that pharmaceuticals prefer to import branded drugs, which may cost up to several thousand dollars per chemo cycle, instead of going through the hassle of locally producing cheaper, albeit essential, equivalent generics."

Bringing this solution to fruition, however, seemed unlikely. "Our patients do not have the time to wait for public health policy transformations. We need immediate actions, even if these are temporary," he said.

During his twenty-five years at HUV, Dr. Masa had learned that the time it takes the state to design and implement new policies follows a different rhythm from the one it takes tumors to grow. He knows that waiting patiently for scarce generics, dealing with EPS bureaucracy, and signing petitions won't be translated into better prognoses or longer life expectancy for patients.

"Something else has to be done in the meantime," Dr. Masa said, gesturing to communicate a sense of urgency. "We must carry on and keep doing our job with whatever is readily available, even if that means prescribing branded medications not typically covered by the health care system. It is preferable to do something rather than nothing. Here is where pharmaceutical representatives become instrumental."

In this chapter I focus on brand-name chemotherapeutic samples, understood as promotional tools used by pharmaceutical companies to increase demand for "drugs with high profit margins" (Alagha and Fugh-Berman 2022, 2). I discuss how the informal relationships between Dr. Masa and pharma reps may transform branded chemotherapeutic samples into technologies of care that reduce treatment uncertainty for low-income patients; that is, samples turn into stopgaps that save patients' time, at least temporarily, while a permanent supply of the same branded medications is secured via tutelas.

To explore how branded drugs are transformed into stopgaps, I bridge three ethnographic events that unfolded independently. The first event, "Generic Disbelief," involves a prostate cancer patient who is puzzled by Dr. Masa's decision to switch a generic chemo drug for its branded equivalent. The second, "Sample Care," describes my encounters with pharmaceutical reps at HUV and conceptualizes branded samples as technologies of care, which have the potential to save patients' time. The third event, "Socio-Chemistry," unfolds at an upscale restaurant in south Cali, where Dr. Masa met with a pharma rep and secured one branded drug sample for one of his patients who suffers from stomach cancer. My hope is that bringing these events together provides a clearer picture of how senior oncologists like Dr. Masa seek to manage the complex relations between generic scarcity and branded overabundance in this country.

GENERIC DISBELIEF

Horacio, seventy-two, is an Afro-Colombian who was diagnosed with stage IV prostate cancer. He is originally from Buenaventura, a port city on the Pacific coast, but moved to Cali in his mid-twenties to work in the sugarcane fields and then as a *bultero* at a factory that produces soy-based food for farm animals.[5] Like many other cancer patients I met at HUV, Horacio's diagnosis came when his symptoms were unbearable. According to his medical history, nagging urinary pain took him to a general practitioner and eventually to a urologist. A digital exam was conducted. Upon completion, blood tests were ordered to check his PSA levels. A biopsy was performed, followed by imaging exams, which confirmed the diagnosis: prostate cancer with bladder metastasis. Horacio was finally referred to Dr. Masa at HUV, who recommended a chemotherapy regime to prolong his life.

For several months the conversations I had with Horacio transpired at the oncology wards and were infused with the typical anxiety experienced by cancer patients who are grappling with the temporal and existential questions associated with their disease. On this occasion, however, I had been invited to his home. He lives in a two-story house located at a busy intersection in east Cali, where the noise of buses, trucks, and motorcycles makes conversation difficult. While seated at the kitchen table, he opened a plastic folder and pulled out a crumpled piece of paper. Holding it with both hands, he sought to unfold it—being careful not to tear it apart in the process. The piece of paper had the HUV seal printed on a corner and cursive handwriting, which was difficult to understand. The more he tried to read it, the more frustrated he became.

But a few words immediately stood out: *abiraterone 500 mg*. This is the name of a generic chemotherapy medication, which is usually in tablet form and works by decreasing testosterone levels in the body.[6] It is considered a relatively inexpensive drug compared to other oncology medications on the market.[7] Because of its proven efficacy and safety record over several decades, standard oncology knowledge considers it an essential medication for the treatment of metastatic prostate cancer and other malignancies (NCCN 2020).

Horacio placed the abiraterone prescription on the table and immediately reached back to his folder. He pulled out a second prescription and read it out loud: "abiraterone, once again." Then he showed me a third prescription. "Enzalutamide," Horacio said, while placing all three documents side by side on the kitchen table.[8] "Do you see? Generics all the way. Dr. Masa has consistently prescribed generic drugs since I got my diagnosis," he uttered in exasperation, as if trying to prove an obvious yet elusive point.

Horacio reached into the folder one last time, tossing around several forms, old prescriptions, and multiple copies of his clinical history. Anticipating the potential mess, his wife stepped in and offered to help, but Horacio declined by making a jerking motion with his hand. She shrugged and left the room.

"Here's my latest prescription," he said happily.

Horacio grabbed the piece of paper and handed it to me. "Camilo, please read it out loud," he asked with impatience. I could not wait any longer to learn what was written in this prescription. Suspense was building.

Holding it with my hands, I proceeded: "Here it says . . . Zytiga."

"That's a brand-name, right?" Horacio asked.

I nodded.

I remembered physicians writing drug brand-names in capital letters on most prescription forms. Next to them, or underneath, generic names were usually included. In Horacio's case, Dr. Masa had written *abiraterone* in parenthesis.

But Horacio was not convinced about my silent gesture of assurance. He kept insisting, "Are you completely sure it is a brand-name?"

I reached for my cellphone and googled Zytiga. Most results came back in English. I paused for a moment and typed "Zytiga español" into the search engine. I clicked on the first link at the top of the results page, which took me to the official Spanish version of the US National Institute of Health (NIH) website. I handed my device to Horacio.

"I told you!" Horacio said. He raised his arms, palms facing up. "I have never been prescribed a branded drug. Do you get why I am surprised? If my EPS has already put up a lot of obstacles to provide cheap generics, just imagine what they would do when I request a brand-name medication! [Laughing loudly.] I just don't get it. If they [EPSs] don't want to give us the cheap ones, why would they provide us with the expensive ones? [Si no nos quieren dar las baratas, ¿por qué nos van a dar las caras?]"

In total, Dr. Masa had written for two abiraterone prescriptions and one enzalutamide prescription over the past three months (one for each month) only to find out these generics were scarce in Horacio's EPS's pharmacy network.[9] Frustrated by this situation, the physician switched Horacio's prescription to Zytiga, a branded equivalent that happened to be widely available during my fieldwork. Horacio, however, thought the physician's choice seemed like a long shot. I didn't blame him. "What was Dr. Masa thinking?" Horacio kept asking, visibly disconcerted.

While it often comes as a surprise for many patients like Horacio, switching from generics to branded drugs is a rather common practice in Colombian medicine—especially when generics are scarce. For Horacio's EPS, however, the Zytiga request was seen as an unjustified expense for a patient like him (low-income, in his seventies, and suffering from a metastatic cancer). Dr. Masa was asked to reconsider his prescription choice.

In the physician's view, the EPS's request was rather feckless. According to him, "Zytiga is what Horacio needed at that moment. Had I followed his EPS's request, I would have needed to tweak considerably the original chemo protocol, which means resorting to second- or third-line therapeutics that may present far more risks for him. Do you get what I am trying to say? Patients are supposed to access the most efficacious and safe medications included in the national formulary, but when financial criteria are added to the health care equation, it becomes okay to prescribe drugs that aren't. That's when we all get caught up in absurd and senseless debates, which look like a 'diálogo de sordos' [dialogue of the deaf], where the parties involved are unable to listen to each other and work together for the sake of helping patients."

Dr. Masa suddenly went silent for a few seconds, as if trying to come up with a simpler explanation for a disconcerting problem. He cleared his throat and made an unexpected reference to Mexican popular culture. "This situation reminds me of Cantinflas's famous phrase, 'Ni lo uno ni lo otro, sino todo lo contrario' [Neither this nor that but quite the opposite]. Do you know what I am talking about?" he asked me.

While trying to explain how the Colombian government seeks to maintain the balance between the financial sustainability of the health care system and the right to health (or between limited resources and unlimited needs), Dr. Masa had drawn inspiration from Mario Moreno, known as "Cantinflas," an accomplished Mexican comedian who is seen as a popular icon throughout Latin America. According to the literary theorist Ilan Stavans (1995), Cantinflas was the master of *mal gusto* (bad taste), which he used as a great equalizer; ridiculing the seemingly insurmountable distance between social groups. For the Mexican philosopher Carlos Monsiváis, what is applauded about Cantinflas is "his non-sense (*incoherencia*) that is the sense (*coherencia*) of the masses, the aggression that is ignorant of the ruling class" (cited in Stavans 1995, 31).

When growing up in Colombia during the 1980s and 1990s, I remember watching several Cantinflas films. In most of these movies, he played the role of an astute mumbler who exasperated his interlocutors by engaging in confusing dialogues in which there is much talk, but nothing is said. As Stavans (1995) has noted, Cantinflas has the ability to conjugate verbs erroneously, coming up with new adjectives and adverbs while failing to complete his sentences.

Cantinflas's confusing prose has allowed Dr. Masa to highlight how "Ni lo uno ni lo otro, sino todo lo contrario" has come to define the paradoxes unleashed by the creation of the national drug formulary, known as Plan Obligatorio de Salud (POS), or Mandatory Health Plan. This formulary was created in 1994 to "guide drug selection, registration and procurement by the government" (Homedes and Ugalde 2005, 64). It was initially conceived as a list of "explicitly predetermined" medical technologies (known as POS drugs), which means only drugs included in the formulary would be covered by EPSs. Drugs not listed in the formulary are considered experimental, cosmetic, or too expensive (known as No-POS), and EPSs are under no obligation to provide them.

When it was first introduced, the formulary was divided into two different lists of medical technologies; one list sought to guide drug selection for patients enrolled in the contributive regime for workers;[10] the other list was intended for the poor and unemployed population, often enrolled in the subsidized regime. Although both lists were composed largely of generics, patients enrolled in the subsidized regime had fewer therapeutic options compared to their "wealthier" counterparts.[11]

Criticized for reproducing socioeconomic inequalities, the two lists were combined into a unique, standardized formulary for all patients by President Santos in 2012. It later became known as Plan de Beneficios de Salud (PBS), or Health Benefits Plan. In this new version of the drug formulary, individuals enrolled in the health insurance regime for the poor and unemployed became eligible for the same health services offered in the insurance regime for workers.

While pivotal, this integration was not enough to counteract rampant inequities in access to drugs or reconcile disagreements about the provision of high-cost medications and the financial sustainability of the health care system (Defensoría del Pueblo 2013; Andia 2018; Prada et al. 2018). The record numbers of tutelas filed to access medical services—including No-POS drugs—attest to the ineffectiveness of these policies, which has transformed Colombia into a country with a high rate of health care litigation.[12]

The tutela has become an invaluable tool for Colombians to protect their fundamental rights. But it has a bizarre catch: when judges rule that EPSs must provide claimants with No-POS drugs (typically branded), insurers pass on their financial responsibility to the state through recobro, or reimbursement. As explained in chapter 2, recobro allows EPSs to request a reimbursement claim from a central public fund known as FOSYGA (today Adres), which decides the amount to be reimbursed according to rules established by the government (Andia and Lamprea 2019; Abadía-Barrero 2022). Hence, instead of penalizing EPSs for delaying access to prescribed medications and threatening patients' right to health, tutelas provoke quite the opposite effect, as Cantinflas would have put it. As such, tutela writs shield EPSs from the high costs associated with the provision of branded No-POS drugs.

Two decades of tutela litigation over drugs have resulted in a substantial increase in public expense for health care services and drugs, the majority of which correspond to branded No-POS meds. Between 2003 and 2009, according to the sociologist Tatiana Andia (2018), the annual growth in No-POS drugs' reimbursement value was 68 percent and reached around US$1.3 billion in 2010. During 2012 and 2015, following her, the total pharmaceutical expense increased 23 percent. In the context of chemotherapeutic drugs, the cost of branded No-POS drugs has continued to increase too, especially due to the arrival of new and more expensive oncology drugs—which are in patent exclusivity.

Tutelas, after all, transform generics into branded drugs. This transformative potential may have a direct effect on the thriving market in brand-name drugs, many of which are still in patent. From Yervoy, Herceptin, and Zelboraf to Avastin and Taxotere, the list of branded chemotherapeutic drugs being requested through tutelas was astounding.[13] Even more puzzling is the fact that many of these drugs were being sold at exorbitant prices (Homedes and Ugalde 2005; Fajardo 2015; Prada et al. 2018).[14] According to studies conducted by Econometría (see Cuevas 2012), local journalists (Quevedo 2013; Semana 2021), and Health Action International (HAI 2008), patients in Colombia (via their EPSs) have been paying for drugs that are up to 240 percent more expensive than most people pay in the Global North.

According to Prada and colleagues (2018), part of the reason that Colombia has tended to have high drug prices boils down to the lack of clear and effective pharmaceutical regulatory frameworks.[15] Consider the two price control mechanisms implemented by Santos between 2010 and 2015:[16] the creation of "price caps on No-POS drugs to be reimbursed by the government," on the one hand, and "the introduction of an External Price Referencing (EPR) system for selected groups," on the other (Prada et al. 2018, 2).[17] Neither of these mechanisms, however, decreased overall No-POS expenditure.[18] On the contrary, Prada and colleagues commented, these measures likely induced an excess of demand or an excessive increase in units sold during 2012–15.[19]

In addition to pricing controls, the Santos administration sought to lower health expenditures and counteract inequity by including in the formulary some of the most frequently reimbursed No-POS drugs,[20] most of which were high-cost medications for cancer. As part of this effort, in 2015 the Constitutional Court promulgated Ley 1751 (Ley Estatutaria de Salud),[21] which transformed the POS formulary from a list of explicitly predetermined technologies into a benefits plan with a list of exclusions, also known as *lista negativa*, or negative list (Andia 2018). In a negative list, every drug or treatment that is not explicitly excluded (e.g., cosmetic or experimental medications) is understood to be included in the formulary.

Despite the new drug additions to the formulary, the number of No-POS drug reimbursement requests has not been reduced.[22] Patients have continued filing tutelas to access branded medications that either have generic bioequivalents on the market or are considered "too expensive" by EPSs. In 2018, for instance, there were nearly 207,000 tutelas requesting access to medical services, including many branded drugs (Defensoría del Pueblo 2019).

These examples show that regulatory frameworks enacted to guarantee access to medicines may have contributed to reproducing generic scarcity vis-à-vis the abundance of branded cancer drugs. It is no wonder that Dr. Masa had turned to Cantinflas's confusing prose to explain the bizarre dynamics that characterize the chemotherapy drug market in Colombia. While Cantinflas's "neither this nor that" could be used to describe the challenges faced by patients as they seek access to generic or branded medications, "quite the opposite" refers to the reimbursement scheme that tends to free EPSs from No-POS (typically branded) drug expenses. This is the mechanism that allows insurers to transfer their financial responsibility back to the state—commonly understood as the opposite of the market under standard neoliberal frameworks.[23]

In the remainder of this chapter I discuss how physicians navigate these Cantinflaesque conditions by tapping into their informal relationships with the pharmaceutical industry. These relationships, I contend, have the potential to make branded (No-POS) drug samples possible for individuals like Horacio, saving them time while tutelas are filed to access the same branded drugs temporarily provided as samples.

SAMPLE CARE

Social science researchers have written extensively on the growing entanglement between pharmaceutical companies and the day-to-day practice of medicine (Dumit 2012; Biehl and Petryna 2013; Sunder Rajan 2017). From the US to Brazil and from Colombia to India, industry gifts (pads, pens, logo bags, etc.), luxurious invitations to international congresses, and the "free" lunch have become ordinary practices (Sismondo 2018).

In this section I write about pharmaceutical reps who frequently hung out at HUV.[24] The discussion that ensues builds on my encounters with sales reps at the Resident's Seminar Room. This is a multipurpose space that features a large sofa, two microwaves, a sink, a rectangular table with eight chairs, lockers, and a restroom. It is a learning space for junior clinicians, who keep their belongings in this room, socialize during their breaks, attend meetings with faculty advisers, and eat and sleep during extended shifts. It also a decompressing spot for sales reps, who would stop in to answer emails, make phone calls, take power naps, and give out pharmaceutical samples and lunch boxes.[25]

Most of my interactions with sales reps occurred through physicians, like Dr. Jesus. He is a second-year oncology resident, originally from the city of Pasto, in the southern department of Nariño close to the Ecuadorian border. After graduating from high school, Dr. Jesus came to Cali for medical school.

Like many other junior clinicians, Dr. Jesus had come to see pharmaceutical representatives as an integral part of hospital life. "Reps are everywhere. That's why they are also called *visitadores médicos* [medical visitors]. They visit us wherever we [physicians] are, reminding us about their products. And they are always easy to spot. They look like *ekekos*," he commented jokingly.

The *ekeko* is a being associated with prosperity and abundance in the southern Andean world (specifically Peru and Bolivia). It is usually represented as a mestizo

FIGURE 3. Ekeko at a street stand. Credit: juhauski72, https://commons.wikimedia.org/w/index.php?curid=69915694.

male figurine wearing the clothing of Indigenous Aymara and Quechua people. While ekekos are usually represented as benign and generous beings, their good intentions cannot be taken for granted. They are demanding entities who must be kept happy with regular supplies of alcohol, cigarettes, and all kinds of miniature gifts (food, appliances, university degrees, flight tickets, currency). In return, these beings watch over the household, ensuring that the miniature gifts they receive will show up in people's lives. As both trader and trickster, as Sandra Rozental (2019) has written, the ekeko "grants access to commodities—the magic of capital itself—in exchange for offerings." Therefore, it is crucial to build good relationships with them.

Like ekekos, pharma reps who visit the HUV are associated with material abundance. These full-size humans grant access to medicines and carry a "payload" too.

Reps I came across would often be pulling one or two wheeled suitcases full of pharmaceutical products, with additional bags on their shoulders. From medical literature, lunch boxes, and nutrition supplements to souvenirs (e.g., Ensure, Avastin mouse pads, and pens), pharma reps always have something for everyone.

When visiting physicians at noontime, reps would usually bring unmarked polystyrene boxes filled with *corrientazo* lunch combos. The word *corrientazo* comes from *corriente*, which means "standard," "ordinary," or "regular." In the Colombian culinary context, *corrientazo* usually refers to regular or generic food—*comida casera* (household/comfort food)—that is sold at diners. Among physicians, it was often perceived as being of lower quality. A typical corrientazo lunch box at HUV would contain Colombian staples like white rice, pasta, plantains, and potatoes (often a little bit of each). It would also include proteins like beef or chicken and a combination of fresh vegetables like lettuce, cabbage, carrots, and tomatoes.

Corrientazo lunch is not intended for everyone. Pharma reps at HUV would usually distribute the lunches to chief nurses and receptionists to help them cultivate rapport, which "translates into more time with physicians" (Sismondo 2018, 142). Medical students and anthropologists like me would also qualify (if we showed up at the Residents' Room at the right time). When reps focus their attention on "higher value" targets, like residents, they distribute a different kind of lunch: brand-name boxes. These are boxes marked with the logos and names of fast-food restaurants perceived by my interlocutors as having higher quality, such as El Corral or Charlie's Roastbeef—two iconic chain restaurants in Colombia that pride themselves on serving "gourmet" fast food: hamburgers, sandwiches, and french fries.

In addition to knowing who gets a branded or a generic lunch, visitadores médicos usually have strong social skills and outgoing personalities. And they are always impeccably dressed. While at HUV, male reps would wear suits, ties, and polished shoes; women would wear dresses or skirts and heels. They would typically be equipped with scripts carefully tailored to match doctors' personalities and neutralize any of their potential evasive moves. Often reps would strategically roam around bathroom areas or exit doors as they anticipated doctors' lunchtime or coffee breaks. The boldest ones knew how to sneak into doctors' offices and give out samples between consultations.

While eating my lunch at the Residents' Room, I would often hear these salespeople using the phrase, "mis doctores estrella [my top doctors]." When I asked Dr. Jesus about this phrase, he explained that pharmaceutical companies keep lists of doctors and rank them according to the volume of drugs they prescribe. These lists are typically organized by neighborhoods and assigned to individual representatives. Each list is called a "caseload" and may typically range from ten to thirty physicians. "A rep who works with oncology drug portfolios, for instance, may get assigned around ten physicians to work with, while another's caseload may be thirty general practitioners," the physician explained.

Regardless of how many doctors they manage to visit each day and the drug portfolio they seek to expand, pharma salespeople rarely seem to improvise. According to Dr. Jesus, "They don't just show up at a medical office expecting to come across a good prescriber, someone who would patiently listen to them for fifteen to twenty minutes." In fact, he told me, reps do research in advance about the prescription potential of each of the physicians they visit, as well as a host of other details that might help connect with them. "Ellos nos hacen seguimiento [They follow us]," Dr. Jesus noted. "They collect data about drugs' sales and learn who their top prescribers are—who tends to prescribe what and which doctors need special incentives from the industry."[26]

Even though stricter ethical regulations have been put in place recently that prohibit pharmaceutical companies from sponsoring doctors and giving them sumptuous gifts to encourage the prescription of certain drugs (AFIDRO 2019, 2022), it is still up to individual doctors to draw the fuzzy line between what is sumptuous and economical, ethical and unethical.[27]

Among the residents I met at HUV, Dr. Jesus is probably one of the most pragmatic when it comes to drawing these lines and engaging with the pharma industry. "We cannot close our eyes and pretend the [pharma] industry has no influence whatsoever on our job. We depend on it," Dr. Jesus said. "Do you think most doctors in Colombia, who often work more than ten hours daily, would have the time to go home every night, spend quality time with partners and kids, and read the latest ten articles on oncology research, treatments, and new drugs? Reps provide us with a valuable service, sharing data on drug development, so we get a sense of what's happening in the latest research and we can make informed decisions."[28]

Dr. Jesus paused briefly and then added a clarification: "Of course, there are pharmaceuticals whose ethical boundaries are questionable. For instance, I know colleagues who had been invited to deliver talks at medical congresses. Prior to their presentations, pharma reps have reached out to them and asked to see their slides. There are other instances when reps ask us to talk about their drugs and use the brand-names at congresses. These cases, I believe, are utterly unacceptable, unethical. But, you know, there are doctors who don't mind, and are happy engaging in ethically questionable practices. Because these doctors have not set clear ethical boundaries from the beginning, they later find themselves too infatuated with of the lures of the industry."

Dr. Jesus concluded, "It is important to know who you are as a physician. Be friendly enough with reps. You never know when you will need them. Just be aware of your own boundaries, don't be too friendly to the point that your medical autonomy and decision making get seriously compromised."

For him, setting personal limits from the beginning is crucial. Yet these boundaries need to be flexible enough to adapt to the unique conditions of the anticancer drug market in Colombia.

"The pharma industry can also be a positive force," Dr. Jesus explained. "Think about drug samples. These are not only marketing tools used to increase sales of drugs. Samples may also be great for patients. But it is important to know how to harness their potential."

Supporters of drug samples argue that they may allow trials before purchase (Alexander, Zhang, and Basu 2008), provide patients with immediate access to treatments instead of enduring delays filling prescriptions and submitting drug requests to EPSs, and may even give doctors a chance to gain experience with new drugs (Alikhan et al. 2010; Tran 2014).

While it may be tempting to argue that drug samples help low-income patients, critics argue that these single dosages are rarely first-line medications, are not recommended by clinical protocols, and are not always effective or less expensive than generic alternatives (Evans and Brown 2012; Brown 2021). In addition, the use of samples may have an effect on the drugs' costs. In countries like the US, for instance, drug samples have proven to raise the cost of health care, "as companies recoup marketing costs through higher prices and increased sales volume" (Chimonas and Kassirer 2009, 2).[29] In the case of Colombia, the widespread use of tutelas and the distribution of drug samples, it could be argued, also play a role in reproducing generic scarcity and transforming this country into one of the most profitable markets for branded medications (see Andia 2013).

My conceptualization of drug samples draws inspiration from Rima Praspaliauskiene's *Enveloped Lives* (2016). In her ethnography conducted at hospitals in Lithuania, she writes about patients who frequently give doctors little white envelopes with money, which are informal payments to ensure surgeries or treatments go well. Envelopes like these, she explains, may even serve to transform rude and grumpy doctors into caring individuals. As a complex patient-doctor transaction, "enveloped" care "exceeds the notion of the gift and/or the bribe while also being included in them" (584). Its reality is not limited to an economic rationality. Hence, rather than a gift or a bribe, Praspaliauskiene conceptualizes these little white envelopes as a practice of health and care. The envelope works as a technology of caring and as a mechanism of healing.[30]

Like envelopes, drug samples in Colombia are technologies of caring that exceed the notion of the gift/bribe. In Dr. Jesus's words, "When we provide patients with samples, we are providing them with time, the time required to continue getting access to their treatments while they request these same drugs via tutelas. We use samples *mientras tanto* [in the meantime]."

Dr. Jesus explained that samples are used *while* patients and their physicians navigate the medical insurance bureaucracy.[31] Like stopgaps, these technologies of care can be used until something more permanent can be procured. In the context of chemotherapeutic drugs, branded samples serve as temporary forms of care provided to patients until a permanent supply of the same brand-name drug is secured via tutela rulings. As a result, pharmaceutical samples may help patients save time, allowing them continuity in their treatments (Alagha and Fugh-Berman 2022). And stopgaps mediate—"mientras tanto"—between elements that are not yet co-temporary, elements that do not yet exist in the same temporal frame, that is, a single branded dosage and the hopes for a permanent supply of the same brand-name drug via the tutela. Likewise, drugs samples may reconcile seemingly different business rationalities and interests: health insurers' need to be vigilant about their spending—which results in treatment deferrals—and global pharmaceuticals' prescription maximization and lobbying efforts to prolong drugs' patent periods (Dumit 2012; Sunder Rajan 2012, 2017).

My encounters with pharmaceutical reps and drug samples, however, were not limited to HUV's Residents' Room and generic or branded lunch boxes. I also followed reps to upscale restaurants where they typically meet with senior "star" physicians, like Dr. Masa. Crucially, while lunch boxes and invitations to restaurants may be common tools used by the pharma industry to build relationships with physicians—and increase the sales of specific drugs, doctors may also harness these meetings to request specific branded drug samples for their closest patients.

SOCIO-CHEMISTRY

I feel slightly uncomfortable with my new clothes. As per Dr. Masa's request, I am wearing an ironed shirt with a tie and formal shoes (which I had to buy specifically for today's meeting). On top of that, Cali's high humidity and elevated temperatures were making my otherwise enjoyable fieldwork quite challenging. And then there was Dr. Masa's zigzag driving. Attempting to drive across Cali at noon is a tricky—often risky—endeavor, especially if one is running late. I manage to hold on tightly to the handle above the passenger door.

Today we will be having lunch at a Peruvian restaurant with Helena, a pharmaceutical representative in her mid-thirties who manages Roche's oncology portfolio for medical providers in north Cali. Her professional ties with Dr. Masa date back almost a decade, when she was working for a competitor and trying to finish an associate degree in marketing. Unlike physicians who are employed full-time at hospitals, Dr. Masa seems to enjoy a remarkable degree of autonomy when it comes to managing his relationships with pharma reps like Helena and prescribing branded chemotherapy drugs that are more expensive than bioequivalent generics. His part-time job at HUV has released him from certain ethical regulations that guide full-time physicians and regulate their relations with reps prohibiting them from receiving direct financial payments from the industry in exchange for prescribing their products.

When we arrived at the restaurant Helena had already ordered several dishes for us: fish ceviche and fried octopus as entrees, among other Peruvian dishes. In addition, a Pisco Sour was waiting for Dr. Masa at the table.[32] Like many other woman reps I had encountered, she was impeccably dressed: white blouse, gray miniskirt, and black heels. A laptop bag was hanging on a chair. Under the table I could see the typical wheeled suitcase that reps pull across HUV's hallways.

The conversation that follows illustrates how senior oncologists like Dr. Masa manage to provide patients with branded drugs by tapping into their social skills and professional relationships with the pharma industry.

Without much preamble, and after taking a sip of Pisco Sour, Dr. Masa made the following request: "Helena, I wonder if you could do me a huge favor. This one patient—a very poor guy with stomach cancer, you know—had to interrupt his chemo regime because trastuzumab has been difficult to get.[33] What are the chances we could get him a sample of Herceptin 440 mg?"

Anti-cancer drugs such as Herceptin and trastuzumab are said to be equivalent in the sense that they contain the same active molecule. Both are available in the same dosages and are administered by "drop" into a vein, or intravenously. Yet they are different because of their prices.[34] While trastuzumab is a low-cost POS generic, Herceptin is a branded No-POS medication. Between 2011 and 2013, a single vial of Herceptin 440 mg was around 5,000,000 Colombian pesos (US$1,600)—more than twenty times what trastuzumab 440 mg costs.

Even though Herceptin is a No-POS and expensive drug, Dr. Masa was confident in the feasibility of his plan for replacing trastuzumab. He shared his strategy with Helena: "Once a writ of tutela is ruled in the patient's favor, we will be able to put him on Herceptin for the duration of his treatment."

Dr. Masa took another sip of Pisco Sour and continued: "You know I am reliable. I have always kept my promises. You are my *socia*." In Spanish *socio/a* is an amigo or friend but not only. It may also refer to business and professional partners.[35]

"Sure. I am here to help," Helena replied. "I will get in touch with my team at Roche and find out whether we have Herceptin samples available."

To overcome the scarcity of trastuzumab, Dr. Masa had tapped into his long history of partnerships with pharmaceutical reps. His relationship with his socia, Helena, would soon be translated into a single branded sample for one of his patients—with the potential of becoming permanent via a tutela.

• • •

Dr. Masa's cell phone vibrates on the table. His secretary is sending reminders about the long list of patients waiting for him at HUV; the time has come to drive back to the hospital. I rushed to finish my dessert while the rep handed her credit card to the server. "Lunch is on me," she told us. Dr. Masa nodded without displaying any noticeable gesture of surprise—as if these kinds of invitations were rather ordinary. From fried squid and fish ceviche to desserts like *suspiro limeño* (sigh of Lima), our lunch had been fully sponsored by the pharma industry. My usual good old corrientazo lunch had been upgraded. Even though I was fairly used to observing drug sample distribution and the enactment of other marketing tools at HUV, this was the first time I had had the chance to witness these practices outside hospitals. Helena had not dispensed pens, caps, or mouse pads but rather invited Dr. Masa and me to lunch and committed to provide Dr. Masa with a branded chemotherapy sample.

On our way back to the hospital I shared with the physician the questions I had kept to myself. "It all seemed so natural," I exclaimed. "Is this how some patients manage to access branded medications when EPSs create barriers or when generics are out of stock within their pharmacy networks?" I asked.

"In some cases, it is. But not always," Dr. Masa answered. "You see, not every doctor has the same kind of connections with the pharma industry. If you haven't devoted time to getting to know them [reps] and demonstrating your prescription potential, then it's more difficult. In other cases, there may be doctors who have built these relations but do not feel at ease with the whole drug sample thing." "It all boils down to a *cuestión de química* [matter of chemistry]," he added.

Puzzled, I asked him to explain.

"Yes, the *química* [chemistry] or *afinidad* [affinity] I have built with certain pharma reps over the years—with my socios. It's a special kind of bond, you see. Química is not something you happen to have with the first random person you meet on the street. If you are fortunate enough to develop química with someone, you better nurture it through a mutual give-and-take. When reps help my patients, for instance, I feel compelled to give something in return, you know. There needs to be reciprocity. That's how relationships are sustainable over time. Everyone must cede something."

To better understand Dr. Masa's cuestión de química, let me take a brief detour into the world of chemistry (literally) and the relations between molecules. In doing so my goal is to see the chemical space as relational, which has the potential for catalyzing ethical reflections (Barry 2005; Bensaude-Vincent 2014), including those I was silently mulling at lunch. Here I follow Bensaude-Vincent and Stengers's (1996, 54) reference to the eighteenth-century French chemist and physician Étienne-François Geoffroy, who considered chemical substances "combinations of molecules and their reactions in terms of association and dissociation." According to Geoffroy, the affinity or strength of chemical relations would vary depending on how the combinations are rendered possible. The chemist, therefore, could be understood as someone who manages molecules and tries to balance their relations.

Geoffroy's descriptions are not foreign to oncologists like Dr. Masa, whose medical expertise revolves around maintaining balance between multiple anticancer drugs. As explained in chapter 1, oncologists must choose combinations of cytotoxic molecules—and their reactions—that can kill tumors without ending the life of patients (Mukherjee 2012). Hence, as Bensaude-Vincent and Stengers (1996) would have put it, weighing what molecules go in and what molecules come out of specific chemical interactions—keeping detailed balance sheets of reactions and organizing them in the form of equations—is a way of increasing the likelihood cancerous bodies withstand aggressive chemotherapy cocktails.

In addition, oncologists need to be keenly aware of the chemical (in)compatibility between drug groups. They need to know which drugs have affinities with which medications, especially when chemo protocols need to be tweaked or when first-line drugs are substituted for second- or third-line pharmaceuticals.

Think about chemotherapeutic generics included in the POS formulary. Cisplatin, for instance, can be used not only to treat testicular cancer, but lung and breast tumors as well. And since carboplatin may be interchangeable with cisplatin, therapeutic options multiply twofold—giving patients a "plan B" in the event one of these lose their potency against tumors or go out of stock within pharmacies. Oncologists also know that doxorrubicin and cisplatin work well when combined. But adding doxorrubicin to an etoposide regime may not always be recommended.[36]

"Like drug molecules," Dr. Masa explained, "humans also have their preferences [affinities] for establishing relationships. It is a matter of knowing who is compatible with whom. This is the chemistry [*química*] I was talking about."

In other words, not every combination of physicians and pharma reps may render branded samples possible, let alone samples that are considered ethically appropriate. And where these socio-chemical relations unfold matters.

The oncologist continued, "Throughout the years I learned that meeting with reps at hospitals tends to be problematic, you know. At hospitals we must focus on our patients. Therefore, I don't like getting samples when I am holding consultations. It is uncomfortable for me and unfair to my patients. It just doesn't look good, you know. A rep standing by my door, giving out gifts, would be seen by many people as *ordinario, de mal gusto* [indecent, vulgar], and unethical. I wouldn't want to run the risk of someone perceiving this as anything other than what it is. To avoid potential misunderstandings, I prefer going out for lunch with reps whenever possible. Meeting with them at restaurants or social events allows me to think outside the box, talk more freely, and ask for samples. And sometimes I don't even have to ask for anything; reps are often quick to anticipate my needs. So going back to your question, I would say it's totally fine to ask for drug samples, as long as your prime motivation is helping patients."

For Dr. Masa, the moral rightness of asking for samples and accepting them would greatly depend on the location where these are enacted. From hospitals to restaurants, drug samples have multiple modes of existence (Latour 2013) and may coexist in several intersecting social worlds while fulfilling the ethical requirements associated with each of them (Star and Griesemer 1989).

As such, when physicians and pharma reps in Colombia move from a hospital to a restaurant, drug samples acquire different ethical connotations.[37] The identity of practices, after all, is dependent on a constellation of elements (Stengers 2005b). From being an ordinario physician who disrespects patients at hospitals to a committed and caring clinician who asks reps for costly chemotherapy samples at restaurants, different places are imbued with unique moral potential.

Throughout encounters like these, samples become relations of care woven into oncology practice as a tool for initiating a substitution of generics for branded drugs—therefore saving patients' time. I argue that the possibility of accessing No-POS chemotherapy drugs such as Herceptin or Zytiga may be partially shaped by drug samples and socio-chemical relations, that is, relations of affinity between socios at a restaurant that extend what physicians and reps could not do in a consultation room. Thus, the kinds of drugs produced and sold by the pharmaceutical industry "can be understood as 'societies' of different elements, as long as we understand that societies are associations of non-human as well as human entities" (Barry 2005, 64).

Drug samples, I have sought to show, cannot only be seen as a practice for increasing Roche's market for oncology products, nor can they be understood merely as a practice of care through which a concerned doctor seeks the favors of a multinational pharmaceutical. The whole of the physician-pharmaceutical relation (see Strathern 2020) I witnessed at the restaurant differed from the individual interests pursued by Dr. Masa and Helena. In other words, individuals who are not supposed to mix—physicians and pharma reps, who typically have different and conflicting interests—suddenly need the other, because alone neither of them would achieve their individual goals.

. . .

The next day, while holding consultations at HUV, Dr. Masa received a text from Helena confirming that two Herceptin vials would soon be shipped to his office—carefully packed inside a white polystyrene box.

"You see, thanks to Helena, I can give hope to many of my patients. That's why she is my socia. This is the minimum gesture of generosity I expect from the pharma industry. Getting drug samples when I need them is a tiny favor in comparison to the large number of Roche prescriptions I write each month. It's like removing a hair from a cat. They know I work with several hospitals in Cali; they know I work with many EPSs. They are not dumb. The market opportunity I represent is important. And there aren't many oncologists in Cali.[38] So pharma reps need to maintain good relationships with us."

Dr. Masa was fully aware that he represented a "market opportunity" for Helena's sales goals. At the same time, he considered her a socia who provides sample dosages from time to time. Their encounter at the restaurant linked molecules with the destinies of a patient through alliances and relations of affinity—*socio-chemistry*. Hence, living longer for certain (often low-income) patients in Colombia would depend on relations at both the molecular and social scales. Dr. Masa's "socio-química" highlights how medicine, social relations, drug samples, tutelas, and Peruvian dishes are intimately connected to make cancer care possible. It may also illustrate how frustrated physicians at public hospitals bypass EPSs' financial vigilance and the time it takes the government to enact new policies, hoping to provide patients with continuous access to treatments—even when cancers are too advanced.[39]

The next chapter explores why standard biomedical protocols, which seek to limit aggressive interventions for terminal cancer patients, were rarely followed in many of the clinical encounters I witnessed. After accessing their treatments, often using samples, patients I worked with faced a relentless and sudden chemotherapization of their dying process.[40] I argue that physicians' moral obligation to help patients live longer, the overabundance of branded drugs, and the national mandate for universal health care have created the perfect storm; toxic and high-cost chemotherapy protocols become the ethically appropriate treatment for many patients whose cancers are metastatic, often in terminal phases. How do oncologists and patients (and their families) decide when *too much is enough* in neoliberal Colombia?

5

Ethics of Exhaustion

Most of the cancer patients I followed in Cali died during, or shortly after, my longest stretch of ethnographic research (2011–13). Some of them went through excruciating pain and anxiety in emergency rooms. A few died at palliative care facilities while health care practitioners pumped artificial calories through tubes inserted into their stomachs. Many others passed away at home while waiting for health insurance approval of their high-cost treatments. Of course, the puzzlement for me was not that a disease like cancer may kill patients. Rather, the surprise was that individuals with metastatic and terminal diseases would waste away while still getting aggressive, out-of-sync treatments.

Oscar, sixty-five, is one of them. Like other prostate cancer patients at HUV, his disease was detected in stage III, when the window of time for surgical removal of the tumor had already elapsed.[1] In addition to the belated diagnosis, he persistently complained of throbbing headaches. Following standard medical protocols, his oncologist, Dr. Zaya, put him on rounds of docetaxel,[2] hoping the tumor would recede. Yet the cancerous mass did not respond well to the prescribed medication; Oscar blamed it on the stress and exhaustion he constantly experienced. On top of that, his headaches grew more intense, an ominous sign the disease was, perhaps, far too advanced for a docetaxel-based chemotherapy.

After doing a bone gammagraphy,[3] Dr. Zaya confirmed that Oscar's headaches were, indeed, the unequivocal symptoms of a skull metastasis. The cancer was then reclassified as a phase IV malignancy, meaning Oscar had an incurable cancer. At such advanced stages, medical protocols encourage physicians to switch from aggressive (often cure-focused) interventions to palliative care, hoping to slow the pace of tumors' growth, control symptoms, and provide quality of life at the end of life.

Instead, Oscar was prescribed a second round of docetaxel as part of what is known in medical parlance as the docetaxel rechallenge. Typically, this chemo protocol consists in the reintroduction of docetaxel in patients who have achieved positive outcomes during an earlier encounter with this drug.[4] Yet Oscar's cancer had not responded to the medication. In fact, no reduction in tumor size or deceleration in its metabolic activity was observed.

Despite his aggressive and incurable cancer, the patient sounded optimistic about the new docetaxel round. While I was hanging out with him at the EPS office, he exclaimed, "This medication is going to help me. I am hoping it makes me live longer and keeps my cancer at bay. I want to feel better and do things I used to enjoy, like going to soccer matches at Pascual Guerrero or visiting family in Buga."[5]

I must admit that I was puzzled when therapeutic plans like his unfolded as if death was not on the horizon, as if there has been a shared agreement (often unspoken) that clinical interventions must continue, regardless of patients' bodily conditions and the emotional stress resulting from the burdensome medico-insurance bureaucracy.

Even though standard oncology protocols I reviewed do not recommend a docetaxel rechallenge for metastatic prostate cancer (NCCN 2019, 2020), Dr. Zaya had decided to stick to it. I understand protocols as a set of predetermined algorithms that regulate physicians' decision-making processes in clinical interventions (see Berg 1998). These are flowcharts of actions that allow physicians to gain information about bodies, to diagnose conditions, and to plan their therapeutic actions accordingly.[6]

When I asked Dr. Zaya about his decision to disregard standard protocols, he answered, "A good doctor should not feel constrained by the guidelines [protocols]. Sometimes it is necessary to think outside the box."[7] Dr. Zaya's plan for treating Oscar was based on a set of clinical algorithms that escaped the standardized oncology flowcharts. In fact, I contend, he engaged in counter-protocols, or aggressive (and highly toxic) treatments—typically used in earlier stages of prostate cancer—as a means of forestalling Oscar's death in the short term. At HUV, these kinds of practices were the norm rather than the exception.

Herein lies one of the central paradoxes of Colombian cancer care: while low-income cancer patients struggle to access chemotherapy on time,[8] when they finally do so the likelihood of reducing therapeutic efforts or transitioning into palliative care is often slim, even when cancers are metastatic. In the cases I witnessed at HUV, physicians felt they had a moral obligation to help their patients live longer, "recuperate" lost time, and bring a sense of justice to their lives, even if that meant resorting to counter-protocols that often inflicted more pain and suffering at the end of life.

To better illustrate these tensions, I consider the case of pain management in the context of the opioid crisis in the US. In his article, "Acute-on-Chronic" (2020a), Stonington describes opioid use as a mutual experience that fuels doctors' and patients' determination to escape pain, "tangled with a biomedical drive to solve problems quickly" (229). The result is what he calls *emergency affect*, which is the "paradox of wanting to avoid opioids and wanting to escalate them" (229). As an affective force, thus, pain permeates medical decision making, "sometimes in directions contrary to expert recommendations or evidence-based protocols" (230).

In Colombian oncology, too, there is an emergency affect of sorts that pulls cancer patients, their families, and clinicians into counter-protocols that do not seem interested in resisting or reversing the cancer. At HUV, for instance, caring for patients who are locked in fights against cancer and the health care system unleashes an emotional whirlpool that pushes physicians in directions contrary to standard oncology protocols and notions of "good care."

According to Dr. Zaya, "We [physicians] are trained to act. Staying frozen, or overthinking things too much, is equivalent to letting patients die. We carry a lot of responsibility on our shoulders; we deal with a lot of stress and guilt." Oncologists like him, I contend, tend to engage in counter-protocols because they do not want to be held responsible for limiting patients' access to anti-cancer treatments, especially low-income patients who have fought so hard, and for so long, to secure access to these medical services. "Patients can still have a life with advanced cancer and should be informed about all the therapeutic options available," Dr. Zaya noted. "A metastatic disease is not synonymous with imminent death, assuming patients get access to the right treatments at the right time."

In this chapter I discuss how oncologists' desire to care for patients in a market-based health care system—entangled with the universal health mandate for universal health—shapes how the end of life unfolds. I analyze how physicians and their patients draw the line between *enough* and *too much* as the latter claim their right to health care while the former does not want to feel responsible for not providing all the treatments rendered possible by tutela writs.[9]

EXHAUSTION

In an ethnography with disabled army veterans in the US, Zoë Wool (2017) coined the concept "in-durance" to describe a mode of waiting for rehabilitation therapies that her interlocutors experience as nonaction, "not a waiting *for*, but a waiting *around*" (79). In-durance, Wool writes, is "not the work of overcoming adversity, of moving on or moving elsewhere, but the practices of making do in a protracted moment of dire and even life-threatening uncertainty that seems so relentless it becomes ordinary" (80). In sync with Wool's thinking, Dwaipayan Banerjee (2020) proposed the term "ethics of endurance" to describe cancer patients' resilience in New Delhi, India, and their connectedness to the present amid adverse conditions for their survival. While *endurance* could indeed be used to describe the challenging (duress or harsh) experiences of many low-income cancer patients in Colombia, in this chapter I use *exhaustion* to refer to the weakening, stressful effects of endurance and physicians' rationale for prescribing aggressive and out-of-sync treatments in the context of metastatic cancers—often pressured by patients and their families. Ethics of exhaustion points to an "ordinary" assumption in the biomedical world that dying from diseases like cancer can only be medically and morally acceptable when all aggressive interventions have been attempted, when vitality has been exhausted or drained from bodies, when life has been reduced to its limits of possibility.[10]

As ethics of exhaustion has grown increasingly quotidian because of the introduction of cutting-edge anti-cancer technologies—along with the promulgation of the right to health—it has also become largely unnoticed, like the air we breathe (see Kaufman 2015). As a result, cancer patients are often caught between inevitable bodily deterioration and aggressive treatments that are presented as their only salvation.

Under these conditions, therefore, it becomes "unreasonable" to question a physician's decision to prescribe a docetaxel rechallenge to a stage IV cancer patient. Patients may even run the risk of finding themselves in pain and alone as soon as they challenge their treatments.[11] "Not taking the therapy," as Lochlann Jain (2013, 17) has written in her now-classic book on cancer in the US, "has something of a moral cast to it, as if it were an invitation to death by cancer, and for a doctor not to offer it for stage II, III, and IV cancers would constitute medical malpractice." For Colombian physicians, unlike their colleagues in the US, getting sued for malpractice is not always one of their top concerns. Oncologists' anxieties at HUV seemed to have revolved around the emotional and ethical consequences of being unable to care for patients who have fought so hard and for so long to access anti-cancer treatments.

Underpinned by the tensions between a market-based health care system and the mandate to protect the right to health, I argue, accessing chemotherapy regimens is at once also the condition that renders these treatments out of sync and turns them into a concentrated poison. In other words, while low-income patients I worked with at HUV were not able to secure access to medical services early in their cancer journey, they did so via tutelas when their cancers were metastatic or terminal, that is, when standard oncology protocols would instead indicate the use of palliation.

When I asked Dr. Zaya to comment on what I perceived as an absurdity, he resorted to a popular saying. "El sistema no raja ni presta el hacha [The system does not allow you to cut wood or borrow the ax]," he said, shrugging his shoulders. The clinician had inadvertently distilled more than two decades of tensions between neoliberal health care policy and progressive legislation. This popular saying illustrates how patients systematically struggle to access their treatments when they should and get them when they shouldn't. This is partly what it means to be out of sync with the time of biomedicine (see chapter 1).

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Miguel, fifty-six, is a colon cancer patient from Tumaco, Cauca, in southwestern Colombia. When he was diagnosed in his hometown, metastatic cells had already broken away from his 4 millimeter tumor and traveled into nearby tissues. Because of the scarcity of medical specialists in Tumaco who could treat him, Miguel was referred to HUV in Cali, where a section of his colon was surgically removed—along with several lymph nodes. Soon after the surgery, his oncologist prescribed capecitabine to kill any remaining cancerous cells in his body.

When I met him at HUV's oncology waiting room, a metastasis had recently been detected in his liver. The patient was put on a different chemotherapy regime that included the generics 5-FU, oxaliplatin, and irinotecan. Back and forth, here and there, doing vueltas or losing time,[12] Miguel had seemed determined to access all his treatments.

When I commended him for his resilience and determination, he responded, "Mijo, hay que hacerle [Son, I must do it]. Going back is not an option." Miguel paused for a moment and then uttered one of the phrases that inspired this chapter: "I have no choice."

Because he had kept detailed records of his clinical history and written proof of the frustrating interactions with the EPS and HUV, it was not difficult for Miguel to file a tutela writ and make the case that his incurable cancer was the result of systematic insurance delays and the hospital's lack of personnel. In less than a week a judge ruled in his favor, mandating Miguel's EPS and the hospital to take action and provide all his treatments without further delays. His physician, taking advantage of the recently granted legal provision, which guarantees the patient's full access to prescribed treatments, decided to switch the generic protocol for branded Zytiga.[13] The patient's tutela had paved the way for a relentless chemotherapization of life at the end of life.

Miguel carried on with his account: "I have the right to health."

I furrowed my brows.

"Of course, every Colombian has the right to health care," he uttered in a stern tone of voice, seeking to contend with my silent expression of skepticism. "I really mean it," he insisted. "Thanks to the tutela my doctors are now able to prescribe whatever I need. The tutela is a kind of *comodín* [wild card]. The government pays for every treatment and drug I need. You see? I will keep requesting each and every treatment I have missed until I have enough *aliento* [strength]. I will do whatever it takes to keep fighting against my cancer, the government, and the health care system. If the hospital does not want to provide a surgery, then tutela goes! If the insurance happens to delay my treatments, then tutela comes! The health care system does work, but you got to fight it."

For low-income, high-cost patients like him, achieving justice in the long term may justify pain and suffering in the short term. "So why not give it a try?" asked Miguel. "Hay que hacerle, mijo" [I gotta do what I gotta do, son]."

Echoing Kaufman's (2015) discussion about ordinary medicine, I contend that the *ethics of exhaustion* in Colombia becomes *logical and possible* for two main reasons. Eventually, most patients who file tutelas get unlimited access to their medications. As a result, the tutela creates a sense of hope in an otherwise impossible future and normalizes aggressive interventions in the present as "the only way" moving forward. It is also logical and possible because the cancers growing inside patients' bodies will metastasize and eventually kill their hosts unless a series of chemotherapy cocktails can be administered to prolong their life. Therefore, reducing therapeutic efforts, or rejecting them altogether, would be seen as an irrational choice, an unbearable defeat.

When I asked Miguel whether he would consider palliative care, he answered, "How am I supposed to ask doctors to stop my treatments? Doing so will kill me. This is not even a remote possibility. I am not quitting."

For Miguel, palliative care did not seem to offer the array of technologies and treatments that oncology typically provides, which he had associated with "better care"—especially when the "wild card" of the tutela had granted him full access to anti-cancer medical services.

I argue that the tutela has tended to set the conditions in which patients' (and their family members') main priority is to confront the health care system, even if that means accessing treatments that may be out of sync with their cancer. Ethics of exhaustion, hence, becomes a seemingly rational impulse that normalizes an attitude of fighting and seeking access to aggressive interventions as the only options, paradoxically when cure is not possible. Therefore, getting more treatments until life is nearly exhausted—bringing it to its limits of possibility—becomes "the logical and right thing to do, the appropriate path to take" (Kaufman 2015, 43).

AMBIVALENCE

Unlike other senior oncologists I met at HUV, Dr. Masa was always available and willing to mentor junior physicians, as well as reassure conflicted anthropologists like me. The following conversation took place at a consultation room where Dr. Masa had met with Lucia, forty-eight, a stomach cancer patient. After reviewing her medical history, especially the notes he took during her latest visit to the outpatient wards, the physician offered a grim warning.

"We must act faster. If you don't get your chemo soon, chances are you will end up with a colostomy for life. Let me be as clear as possible: Do you want to have a tube connected to your stomach?"

Lucia nodded in silence.

I could tell the patient was upset, yet unsure how to communicate her concerns to the doctor. She stayed silent.

The physician furrowed his brow and provided some practical directions for her: "Please grab all this paperwork [pointing to several sheets of paper on the desk] and take it to the insurance office. If necessary, yell at the office clerks, let them know you will sue them [via a tutela]!"

Dr. Masa was visibly irritated. He hit the desk with his fist, then grabbed a prescription form and wrote, "URGENT, life-threatening condition," hoping the insurer would speed up the burdensome authorization process.

Without making eye contact with the physician, Lucia stood up and grabbed the insurance forms and prescriptions that were scattered on the desk. She turned around and left the room.

Before his next patient showed up at the door, I turned to Dr. Masa for clarification about this encounter. Given his hectic schedule and the large number of patients he sees per day at HUV, I quickly learned that I had to ask questions "on the spot" if I hoped to understand the complex interactions I witnessed. Conducting ethnography at HUV was becoming a matter of thinking and asking questions fast enough. The more I waited to debrief my puzzlement and confusion, the fewer details I would remember and the vaguer the physician's answers would be.

"How do you go about this?" I asked the doctor.

"How do I go about what?," he replied, visibly exasperated by my vague and sudden question. Putting my question on hold, he stood up and waved his hand at a clerk, who seemed fully absorbed in a cell phone conversation.

The physician exhaled heavily. Frustrated, he sat down. "Compadre, please do me a favor," he asked me. "Would you mind looking for the head nurse and telling her to come? I want to know if they [hospital administration] are planning to fix the air-conditioning anytime soon! These consultation rooms have turned into boiler rooms. I cannot keep working like this."

Grumbling and visibly upset, Dr. Masa sat down. He placed his right hand on his forehead and his right elbow on the desk, tilting his head slightly forward.

"What was your question? I am sorry, Camilo," he said.

There was a prolonged silence in the consultation room. It took me a couple of deep breaths before I was able to articulate my ideas again.

"I guess I have a hard time thinking about all these patients, the patients I have come across at HUV," I managed to say. "Most of them have metastatic cancers. They are literally rotting alive and struggling to catch up with their diseases. Some of them never come back to consultations. Those who return often do so because they have been granted a tutela—but then it is too late. So I am wondering about the ethics and medical protocols informing your decision to keep these individuals hooked up to aggressive chemo and whether their anti-cancer treatments should be complemented with other medical practices, like palliative care."

Dr. Masa pulled out a white handkerchief from his pocket and dried the sweat that was dripping down his forehead and sideburns.

He checked his watch and explained, "All of these patients [pointing at the waiting room] are entitled by law to access the medical care they require. Few of them would ever be willing to give up on their fight against cancer and the unequal health care system. They would do whatever they can to make the government pay for the lost time, even if that means filing tutelas to access treatments that would hardly benefit them."

Dr. Masa's words illustrate how oncologists like him are caught in a complex dilemma. On the one hand, they hope to prolong life by resorting to more technology and aggressive interventions, even if these actions may seem to go against their Hippocratic oath and evidence-based oncology protocols. On the other hand, they may feel they need to side with patients' (and their families') systematic struggle, which often means advising them on how and when to file tutelas, helping them bypass the EPSs' bureaucracy, or harnessing the power of their professional and personal relations with pharmaceutical representatives.[14] Regardless, the general assumption is that permanent action and more interventions are the "right" and "logical" choices to guarantee patients' right to health.

"I must be honest," Dr. Masa said. "The thing is complicated."

He stood up again and took a few steps inside the cramped consultation room. He continued, "We [physicians] are often caught between a rock and a hard place. Sometimes this is the result of naive misunderstandings or lack of honest communication between health care providers, patients, and their family members. Many people have bought into the idea that oncology—and medicine in general—is meant to cure, especially when diseases such as cancer are treated early. Even public health campaigns build on this assumption. But things are not as straightforward. Things are not black or white."

Dr. Masa paused his explanation for a moment and peeked outside his office. After making sure no patients were standing nearby, he turned around and commented in a softer tone of voice, "Many, many cancers are not curable, especially when metastases have already occurred. Even cutting-edge technologies can hardly guarantee anything in the cancer world."

I was disconcerted by Dr. Masa's words. His explanation did not seem to match what he often tells patients in the consultation rooms. He contended that most cancers are fought with technologies that are either uncertain—in terms of their results—or too expensive for most patients. Yet physicians like him have chosen the ethics of prescribing generous quantities of the same drugs they feel ambivalent about.[15]

I made another effort to reformulate my initial question: "I guess I am wondering about what makes you keep prescribing more chemotherapy in the face of patients' irreversible decay and imminent death."

Dr. Masa replied with a question: "What would you do if you were in my shoes, Camilo?"

I felt caught off guard and unable to answer.

Disgruntled, the physician carried on with his response: "Look, I cannot just sit down and cross my arms. What else am I supposed to do?"

I frowned, as if trying too hard to come up with an answer.

Dr. Masa exhaled heavily, puffing out his cheeks, and added, “Should I tell them [patients] to go home because there is no hope? Hay que hacerle [We gotta do what we gotta do]. I cannot prescribe valerian drops or Bach flowers, administer a lethal dose of anesthetics, or have existential conversations about their [prolonged silence] . . . death. What kind of doctor would I turn into if I stop prescribing these chemo regimes? I would certainly be signing their death sentence, and I do not want to feel responsible for that. They have swum a long way to end up dying at the shore. Do you know what I mean?”

Dr. Masa seemed to be clear about the kind of doctor he is—or aspires to be. He is an action-driven and caring physician who staves off death by intervening in cancerous bodies through the variegated oncological tool kit at his disposal. Over the past twenty-five years he had been relying on chemo, surgery, and radiation as the main tools for killing or shrinking tumors. Therefore, efforts not directed at curing bodies and prolonging life may feel like surrender, even when patients are at the end of life. Slowing the pace of care or reducing therapeutic efforts would likely result in deleterious effects; patients’ lives and physicians’ own anxieties and professional reputation are at stake. Under these conditions, hence, wearing patients out is preferable to not doing “enough.” In other words, “sins of omissions are worse than sins of commissions” (Stonington 2020a, 236). A common figure of speech in medical ethics, this phrase may help explain why physicians like Dr. Masa and Dr. Zaya did not feel comfortable with presenting their patients with the option of reducing therapeutic efforts or transferring them to palliative care when their symptoms were still manageable.

Because patients and doctors have invested so much time and energy in securing access to medical services, reducing or refusing these services altogether may seem irrational, unfair, truly unthinkable—which is in line with the assumption that patients (and their doctors) have no choice.

Undoubtedly, oncologists at HUV keep doing their best to care for patients, reading pathology reports, palpating lumps, asking questions, filling out burdensome insurance forms and petitions. Yet, almost simultaneously, they acknowledge the frustration and impotency of being unable to properly treat most of their patients. Despite Dr. Masa’s intentions to quickly catch up with the time of tumors, he often fails—and he admits it. He grumbles, sweats profusely, exhales heavily, and puffs out his cheeks.

Dr. Masa’s reflections introduce a fundamental ambiguity in his oncology practice and reveal some of the ways in which his ethical structure unleashes its own reversal (see Whitmarsh 2008).[16] There is a conflict between what he thinks is right and what he feels he can, and must, do. And of course, it encompasses the frustration and impotency as the clinician tries so desperately to treat a disease that is often defined by its “unlimited and voracious growth” (Mukherjee 2012). For doctors like him, “good” cancer care may not only mean shrinking tumors, but also taking patients to the limits of their lives. In Dr. Masa's treatment of cancer, it gradually became clear to me that the boundaries between concern and neglect, hope and despair, were getting constantly blurred (see Banerjee 2020).

Like Sisyphus, Dr. Masa has accepted pushing the rock of cancer up the hill, just to watch it roll back. Only when there is *nothing else to do* and cancerous bodies become dramatically deteriorated due to the disease itself and the aggressive (often out-of-sync) rounds of chemo, does dying become possible and acceptable.

PALLIATIVE ANXIETY

In this section I shift my ethnographic attention from resource-scarce HUV to Betania, a long-term care medical facility belonging to the private, cutting-edge hospital Valle del Lili. Surrounded by lush tropical vegetation on the outskirts of south Cali, Betania was conceived for patients who require either postsurgery rehabilitation before returning to their ordinary routines or symptom management on their way to dying. Although this medical facility has contractual agreements with insurers for the poor and unemployed (the subsidized regime), the patients I encountered during my visits were enrolled in insurance for the working class (the contributive regime) and the wealthier (prepaid).

Here I shadowed a palliative care physician during her rounds with terminal cancer patients.[17] I call her Dr. Soto. Her job is to make sure symptoms are under control and, on death's arrival, to make sure individuals are as comfortable as possible. Before interacting with patients and their family members, she would ask me to disinfect my hands by pressing on the antibacterial dispensers attached to the door frames of each private room. I was repeatedly reminded that any virus or bacterium could easily grow unchecked and kill most individuals at this facility.

Even though my observations soon became monotonous, the scenes I witnessed at this facility were no less difficult to bear. At each room I would come across mostly bedridden patients who were mildly or fully sedated, the majority of them connected to a wide variety of medical devices by means of urinary catheters, oxygen pipes, and nasogastric tubes. Impeccably dressed in blue and white uniforms, women nurses would constantly swing by the rooms. As part of their job, they must check on patients' vital signs, change bed sheets and diapers, document urine output, and administer painkillers such as Lyrica, hydromorphone, morphine, and tramadol, among others. Each room has a medium-size TV set hooked up to a metallic wall mount. The TVs remained on for hours; news broadcasts, talk shows, and lunchtime *telenovelas* (soap operas) created constant background noise that blended with the machines' beeping and the rushed footsteps of health care staff.

Eyes closed, Clemencia, seventy-eight, is lying on her back. The patient's bed is tilted at a 45-degree angle. Her hips are slightly flexed to prevent bed sores. To aid in providing comfort and safety, several pillows and blankets have been tucked between her body and the bed's metal rails. When Dr. Soto and I entered the room, the patient's only daughter had just returned to check on her mother. A nurse warmly greeted her and shared the latest updates about Clemencia's overnight care. "It was rough for her," the nurse said, while caressing the patient's hands. "Her morphine dosage had to be increased to help her relax," she further explained. Throughout the last year Clemencia's stage IV esophageal cancer (esophageal squamous cell carcinoma, to be precise) had been treated at Valle del Lili's main hospital with a combination of surgery, chemotherapy (Herceptin), and radiation. Her prepaid insurance had given her—and her treating doctors—a wide range of therapeutic options to choose from. But her disease quickly became resistant to the prescribed treatments and metastasized to the liver.

The drugs and the cancer combined had exhausted Clemencia physically and emotionally, leaving her, her daughter, and the health care practitioners in a complicated situation. According to Clemencia's daughter, "One day they [physicians] informed us that all therapeutic possibilities had been exhausted, that it was time for palliative care. But, of course, I got upset. I felt like we were getting dumped—that the oncologist had given up on her. It felt like a punch in my stomach, you know. And I must be honest, it took me a long time to come to terms with the reality. Despite the different medical approach, they [physicians] assured me my mom would continue getting the best care possible until the very end. When cure is impossible, care is still possible, they told me."

A month before, when Clemencia was referred to this long-term medical facility, a team of palliative care givers, family physicians, respiratory therapists, and psychologists was brought together to help her cope with the disease. In addition, Clemencia was immunosuppressed because of the natural progression of the disease and the aggressive treatments she had been receiving. On top of that, she was having a hard time swallowing. While moving food or liquids into our stomachs is second nature for most of us, for Clemencia this action had turned into a risky practice due to her esophageal cancer. Echoing Jessica Zitter's (2021) detailed and gripping descriptions of her clinical work with dying patients at a hospital in the US, Clemencia's health care providers had pumped artificial calories directly into her stomach. These calories, however, often were accidentally pushed into her lungs. When that happened, Clemencia felt she was getting drowned or asphyxiated.

When she was classified as terminal and referred to this medical facility, her chemotherapy and radiotherapy sessions were halted. "But it was already too late to control her symptoms," noted Dr. Soto. "Most oncologists dump patients into palliative care units when they have exhausted all available options. They tend to focus on fighting the disease, shrinking tumors, extirpating masses. So by the time we get these kinds of patients—well, you know, they are embattled and weak.

So we must figure out how to manage the numerous side effects triggered by treatments and the natural progression of the disease."

Health care staff at this facility were diligently trying to keep Clemencia comfortable, tinkering with pain medications and hoping to find effective and safe combinations for her. Too little morphine, and her pain would not be properly controlled. Too much of it, and a series of grave complications would be unleashed, which included constipation, urinary retention, and respiratory depression, among others.

"I can barely keep up with my mom's treatments," Clemencia's daughter protested. "Not long ago I used to know exactly what [treatments] she was getting. But not anymore. The combination of the cancer, its symptoms, and her long list of medications is triggering side effects you can't even imagine. It's just so complicated. I feel physically and emotionally drained. That's why I recently began spending the nights at home. I needed some rest."

Indeed. Clemencia's symptoms were out of control. And she did not seem to be "moving" in the sense of getting closer to regaining her independence or engaging in some of her favorite activities—like crocheting or tending her plants. She was, in fact, living on her way to dying. Her oral morphine had constipated her, so doctors temporarily stopped this medication and instead administered a laxative to induce her bowel movements. Drugs such as hydromorphone and Lyrica had been introduced at earlier stages, but Clemencia did not seem to tolerate them well. In addition, nurses would constantly swing by her room and puncture her veins to inject fluids. At this stage of cancer, every intervention, every drug, would unleash a series of side effects that medical practitioners had to be ready to counteract.

Two weeks after my initial visit to Clemencia, I was told she had been admitted to Valle del Lili's ICU with nosocomial pneumonia.[18] As documented in her medical history, her pneumonia was the result of aspirated food that had caused an infection. Health care providers were quick to respond, however. Her oxygen levels improved after she was put on antibiotics. "That was hopeful news," said her daughter. "We were still optimistic at that point." Her mother, after all, seemed to be getting somewhere with her treatments—away from a life-threatening infection.

According to Dr. Soto, these complications are not rare in patients with esophageal cancer. After Clemencia's ability to swallow was affected by the disease, she found it difficult to keep eating. To make things even more frustrating, patients like her who are enrolled in prepaid insurance plans may go in and out of medical facilities through what Zitter (2021) calls "revolving doors." This is the back-and-forth between ICUs and long-term medical care that patients like Clemencia may suddenly find themselves caught in. Paraphrasing Zitter, as soon as physicians manage to cure one infection, the next in line attacks with vengeance.

Not much time passed before Clemencia was readmitted to the emergency room for another pneumonia. This time, however, her body was too weak. The emergency physician inserted a feeding tube to prevent future infections of the respiratory tract. When I commented on Clemencia's case to Dr. Soto, she grudgingly mused, "Some of us [doctors] tend to think that a feeding tube is the right choice because it makes people live longer, especially patients who have tumors in their throat or esophagus. But this is not always the case; it may rather inflict unnecessary pain on patients and unleash a series of infections and injuries, which are especially difficult to manage. One of the most common problems is when their stomach contents escape up into the lungs, drowning them as a result."

Clemencia's team of physicians found themselves between the cancer's relentless growth and the rehabilitation protocols that were understood as the only and "logical" options for keeping her alive. Despite the risks and marginal therapeutic benefits, a feeding tube was finally inserted in Clemencia's stomach. Soon after, however, she was referred—once again through revolving doors—to Valle del Lili's ICU. While physicians desperately sought to contain the emergency, her daughter recounted, visitors were allowed to see the patient for a maximum of one or two hours per day. On top of that, they were required to wear personal protective equipment (PPE) to prevent exposing Clemencia to new and potentially lethal infections in her lungs.

This time, however, the patient did not return to Betania's palliative care facility. A more aggressive pneumonia won over her fragile immune system. Clemencia's "timely" treatments and her journeys through revolving doors, in part rendered possible by her prepaid insurance and her daughter's love, had morphed into a form of care that intensified pain and exhaustion while seeking to stave off death. Her case demonstrates (along with Juana's, discussed in chapter 3) that social class determines timely access to treatment and that even in resource-rich settings like Valle del Lili, patients and their family members experience high degrees of anxiety and pain as a result of prepaid insurance shaping how cancer treatments ordinarily unfold. It also highlights the common practice of referring patients—like Clemencia—to palliative care when their bodies are extremely weak and their cancers have metastasized throughout tissues and organs. Hence, managing cancer symptoms becomes an impossibility of sorts, a nearly futile and frustrating practice.

Situations like these are largely fueled by the ethics of exhaustion, a rationale that embraces the either/or dichotomy of curative treatment or palliation. What makes the ethics of exhaustion so insidious is that it enables caregivers to feel reassured that their actions are in sync with notions of acceptable morality (see Kaufman 2015). By increasing the number of prescriptions and providing more medical services—the conventional biomedical assumption goes (Dumit 2012)—we have a greater chance of defeating diseases and living longer. The faster clinicians act, and hence the longest therapeutic "distance" of patients, the longer they live.

This is the rationale associated with the ethics of exhaustion; while it builds on the *logical* and *right* decision to make patients live by doing more in the flow of time (Stonington 2020b), relying on more aggressive treatments and technologies may only suspend the time of dying in the short term for the long term. This form of care, however, runs the risk of morphing into the mode of disregard and suffering experienced by Alice Rivières, a writer with the genetic mutation for Huntington's disease. In Rivières's personal account of her encounter with the testing technology for this condition (and its future-making capabilities), she noted that one of medicine's obsessions "is making sure that people do not die, or if they do, that is absolutely not medicine's fault" (2021, 33). This is partly what had informed Dr. Masa's and Dr. Zaya's rationale; they did not want to feel responsible for the death of their patients after all.

SPEED

I conclude this chapter with a short reflection about speed and the reasons that aggressive interventions for metastatic cancer patients tend to have been transformed into "the only path" moving forward—on their way to dying. In what follows I set out to imagine a medical ethics not exclusively defined in terms of speed, or the need for being faster and "tougher" than cancer.

Here I echo the anthropologist Julie Livingston (2019) and her experimentation with parables, which she used to illustrate *self-devouring growth* in South Africa. In literature, a parable is a tool that provides meanings through the creation of parallels or comparisons. In the context of geometry, "parable" refers to a curve that resembles the path of something that is thrown forward and high in the air and falls back to the ground. In such a journey, Livingston (2019, 2) writes, "we travel out, unfolding the metaphor in a parabolic shape. By journey's end, we will have returned to the same plane in which we started, but somewhat further along the way, in the hopes of having learned something from our experience along the way." The reflection that follows travels out in a parabolic motion and unfolds along Lewis Carroll's *Through the Looking Glass*. By traveling out into this novel, my hope is that a parabolic journey will allow me to render visible some of the main assumptions about living with cancer in Colombia—and dying from it—that have become ordinary, just like the air we breathe to stay alive.[19]

In *Through the Looking Glass*, Carroll describes a scene in which Alice finds herself in a fantastical realm adorned with beautiful gardens. As she wanders, bewildered by the surreal landscape, she stumbles upon the Red Queen—a towering, human-sized flower that runs at an astounding speed. The Queen explains to Alice that the entire garden is, in fact, a gigantic chessboard, challenging her to a competition of speed. If Alice manages to move rapidly all the way to the final row of the chessboard, the anthropomorphic floral being vows to bestow upon her the title of queen.

The young girl accepts the challenge. She gets on her marks under the comforting shade of a tree. When the Red Queen gives the signal, the girl starts running as fast as she can.

> "Now! Now!" cried the Queen. "Faster! Faster!" And they went so fast that at last they seemed to skim through the air, hardly touching the ground with their feet, till suddenly, just as Alice was getting quite exhausted, they stopped, and she found herself sitting on the ground, breathless and giddy. The Queen propped her up against a tree, and said kindly, "You may rest a little now." Alice looked around her in great surprise. "Why, I do believe we've been under this tree the whole time! Everything's just as it was." "Of course, it is," said the Queen, "what would you have it?" "Well, in our country," said Alice, still panting a little, "you'd generally get to somewhere else—if you ran very fast for a long time, as we've been doing." "A slow sort of country!" said the Queen. "Now, here, you see, it takes all the running you can do, to keep in the same place." (Carroll 1999, 32–33)

In this excerpt, Alice found herself in a dreamlike world where Newtonian physics or conventional logic did not seem to apply. Her desperate attempts at running and beating the Red Queen were not being translated into a meaningful change of position across the gigantic chessboard. Even though Alice ran as fast as she could, her position in relation to the nearby tree—the point of reference—did not change. In her desperate run, there was motion—her arms were rapidly swinging back and forth, in sync with every stride she took—yet there wasn't a corresponding shift in space. While it took all her efforts to take rapid strides, she frustratingly remained in the same spot. Panting and near the brink of total exhaustion, Alice came to a rest and squatted under the shade of the tree.

What can this scene tell us about cancer care in general and the bizarre assumptions that sustain the ethics of exhaustion in Colombia's market-based health care system?

Catching up with diseases such as cancer, and anticipating possible metastases, is what really holds oncology together. Caring for patients, hence, becomes a matter of speed,[20] being faster than a disease defined by its temporal urgency and self-devouring growth (Livingston 2012, 2019).

Yet getting faster access to screenings and anti-cancer medications does not necessarily give patients more time to live; it may often increase the time that transpires between diagnosis and death (Welch 2006; Esserman 2010; Mukherjee 2012)—which may lead to overtreatment of potential malignant lesions that probably would never have developed into life-threatening conditions.[21] Moving too fast along this path, hence, may prevent us from becoming aware of the conditions that have transformed "hay que hacerle" (we gotta do what we gotta do) into such a powerful single story,[22] a story in which cancer is presented as an external enemy that "unfairly" attacks our bodies, a story of struggle and fighting as the only and ethically right choice *moving forward*; a motion that often implies directionality and the hope of living longer.

This was Clemencia's case but not only. Even though her radiotherapy and chemotherapy sessions had been suspended, Clemencia had gone back and forth between the ICU and the long-term care facility. She had endured several nosocomial pneumonias, gotten drowned with aspirated food that lodged inside her lungs, and was connected to an artificial ventilator until her body was unable to withstand the next infection in line.

Prescribing more treatments and staving off death to cancer become the logical and right things to do, until death has become an all too obvious presence. While oncologists I worked with sought to care for patients and prolong their lives, part of that means practicing counter-protocols that may arguably inflict more pain and suffering—shortening patients' lives as a result. In Oscar's case, for instance, his oncologist prescribed a second round of docetaxel, even though the first attempt was unsuccessful at shrinking the tumor. For Miguel, once he was granted a tutela, his oncologist felt compelled to "regain" some of his lost time by switching the prescription from a generic cocktail of drugs to Zytiga. Both the patients and their family members would spend their last days doing burdensome paperwork while the patients received aggressive anti-cancer treatments.

In this chapter I explored terminal cancers at different intersections of biomedical and health insurance practices, hospital infrastructure, and ethical standpoints that push physicians and patients (and their family members) into a relentless chemotherapization at the end of life—largely because "there is no choice." Recall my conversations with Dr. Masa. While he acknowledged that most chemotherapy regimens would hardly benefit patients, he kept prescribing the drugs on a regular basis. This seeming ambivalence reflects how procedures and treatments that are usually considered risky and unnecessary by standard biomedical protocols become ordinary.

How could terminal cancers be rendered more die-able and, above all, transformed into a healing experience, especially for patients (and their families) who have been caught between relentless fighting, the disfiguring effects of cancer, and agonies? These are the questions I set out to explore in the epilogue of this book.

Interim II

Catching Up with Pepe

After waiting for a couple of hours at the HUV oncology wards, Silvia stood up, grabbed her purse, and glanced underneath the chair to make sure she was not leaving any of her belongings behind. She knew it was time to make her way into Dr. Masa's office—before his next patient arrived. Albeit with hesitation, she leaned toward the opened door and peeked inside. Dr. Masa saw her and immediately waved, inviting her to come in, as if he had been anticipating this encounter.

Silvia did not have an appointment with the physician. She is not even his patient, nor does she have a cancer diagnosis. Her brother, Pepe, does. He has metastatic gastric cancer. After accompanying him to periodic appointments with Dr. Masa, she gradually came to develop a rapport with the physician. That is how she knew the moment was ripe for rushing into his office, unannounced. "I am fond of him. He might be bad-tempered at times, but he is forthright," Silvia said. Today she was hoping to get advice and reassurances about Pepe's gradual deterioration, without having his brother around. Most conversations about her brother's death had been avoided by Silvia—until now.

The woman entered the examination room and sat down on a chair that Dr. Masa had pulled out for her.

"Well, tell me how's Pepe doing," the physician asked.

Silvia shrugged. While staring at the floor, she mused, "You know, not so good. The last few days have been quite rough. His stomach hemorrhages are getting worse."

"Just make sure you keep providing him with the pain medication, okay? And give him ice to suck. Cold temperatures help control the bleeding," Dr. Masa advised. "The disease is progressing at great speed."

There was a prolonged silence in the office while Dr. Masa shuffled several documents that were sitting on his desk. "Do you have copy of your brother's endoscopy?" he asked.

Silvia opened her purse, pulled out a plastic folder, and placed it on the desk. Dr. Masa opened it and skimmed its contents. He was looking for one of Pepe's first endoscopies.

"Can you see it? Just look at the initial image taken six months ago. It used to be the size of a coin," the physician explained, while turning the pages until he came across the latest endoscopy image, taken roughly a month ago. "Well, that little coin you just saw has now grown to the size of a tennis ball." He paused and handed the picture to Silvia. "That's why his gastric hemorrhages are happening more frequently. He is simply unable to pass food into his stomach. No Ensure or vitamins of any kind will help him at this point. Believe me, we have tried it all."

Silvia stared at the physician, as if waiting to hear what she intuitively knew but did not feel comfortable discussing.

"You are aware Pepe is dying, right?" Dr. Masa asked.

His words took me by surprise. The physician had seemingly shared the difficult news without much preamble, *sin anestesia* (without anesthesia), as we colloquially say in Colombia.

Silvia covered her face with her hands and burst into tears. Dr. Masa inhaled deeply and gently placed his hand on her shoulder. He mused, "I am sorry. Your brother has been a fighter. But his body is too weak and cannot keep up with his cancer anymore."

The examination room was silent for a few seconds. Then the clinician shared information Silvia would soon find useful. "Have you made any preliminary arrangements with a funeral home?" Dr. Masa asked.

Silvia nodded.

"Please consider doing so as soon as possible. And pay attention to what I am going to say. If your brother passes away during evening hours, don't bother coming to the hospital at that time. Death certificates are only issued during working hours, between 7:00 a.m. and 5:00 p.m. Once you get here, stop by the emergency room and bring your brother's cédula with you. Tell the nurses that your brother has just passed away and that you need the certificate. Let them know the time of his death. Once you are issued the certificate, contact the funeral home that will oversee the transporting and preparation of his body."

At around 4:00 a.m. several days after witnessing this encounter at the oncology wards, I received a phone call from Silvia. It did not take me long to fathom the gravity of her call. Pepe was in deep distress. The night before, he had gone to bed just to be woken up to another hemorrhage no amount of ice seemed capable of halting. His sister had the ominous feeling this would be the very last crisis for him.

As soon as I could, I took a taxi and headed to their house in El Vallado neighborhood in east Cali. When I arrived, Pepe was lying on his bed, in the fetal position, just skin and bone. His breathing felt heavy. As a result of the progression of the disease, his facial features had dramatically changed. He did not seem the same person I had hung out with three weeks earlier. I could barely recognize him.

He was in agony after enduring a frustrating year of deferred treatments, toxicity, vueltas, waiting in line, yelling at insurance representatives, filing tutela writs against his EPS, taking buses, and asking nurses to pump "Diablo rojo" (red devil) into his veins. Pepe's polychemotherapy—composed of antiemetics, cortisone, oxaliplatin, epirrubicin, and Xeloda—did not result in higher chances for survival or lessening his pain. Throughout his medical journey, doctors and family members had encouraged him to be resilient. Like all Colombians, he had the right to life and health after all. Thus, he was expected to fight and persist. While Dr. Masa was focused on putting together the chemo protocols, Silvia was desperately asking medical staff for Ensure and vitamin prescriptions. Yet at every step of the journey, his tumors grew increasingly more aggressive. His funeral service would be held just a few blocks away from HUV and the EPS office, the same places he had spent countless hours waiting to go somewhere, on his way to dying.

Epilogue

Emancipatory Futures

Synonymous with "mob," "throng of people," or "social uprising," *tropel* has come to shape the intersections of health care in neoliberal Colombia. In my mind, tropel evokes images of individuals waiting patiently at health insurance offices while being irritable enough to yell at representatives, hopping on intermunicipal buses, and enduring endless road trips, clutching hard copies of their clinical histories and being ready to file tutela writs to protect their right to health.

For many cancer patients I met at HUV, the slogan *sin tropel no hay salud* (no fight, no health) was more than a rallying cry shouted by protesters marching down Calle Quinta, or a mere set of graffiti sentences written on public hospital walls. It was, in fact, a powerful mantra that redefined the goals of care and the meaning of treatments. As such, the stories of cancer patients and their families presented throughout this book are not so much about their will to live (see Biehl 2009) as they are about their persistence to become visible before a state that has systematically neglected them. Gaining access to anti-cancer treatments, I have argued, becomes a vindicatory practice in and of itself, regardless of the outcome. The point of gaining access to treatments is to exercise one's rights.

While tropel has allowed patients to access medical services, often via tutela writs, however, it also has the potential to inflict more pain and suffering in the long term—at the end of life. Consider tropel in the context of acute inflammation. Physiologically speaking, inflammation is an organic process by which our bodies' immune system readies itself for action, seeking to protect us from elements that are perceived as threats—such as bacteria and viruses. Once the perceived threat has been eliminated, our immune system scales back its defensive activity, thereby allowing the body to repair its tissues (e.g, grow healthy cells to replace dying or diseased ones). While inflammation is beneficial for short periods (Dai et al. 2020), once it becomes chronic the body loses its capacity to heal and grow new tissues, setting the right environment for the development of a wide range of conditions, from Alzheimer's disease and heart disease to diabetes and various forms of cancers (Kinney et al. 2018; Sorriento and Iaccarino 2019; Coussens and Werb 2022).[1]

Similarly, the ever-present tropel that has motivated patients to join protests and endure exhausting vueltas (Sanz 2017), for instance, may be the same impetus that normalizes aggressive interventions as "the only way" moving forward (see chapter 5).[2] When cancers become terminal or metastatic, patients who have managed to access treatments via tutelas tend to be more focused on keeping these same services rather than reducing therapeutic efforts or transitioning to palliative care.

Dr. Artesano once complained during his palliative care consultations at HUV, "These patients are fantasizing about an imaginary future instead of placing their attention on what is happening with their disease processes right now." Similarly, tropel seems to have acquired the bizarre potential to remove patients from their present situation—a seriously deteriorated body—and direct their attention to an uncertain future that increases their anxiety.

At the same time, I came across many oncologists who were engaging in counter-protocols,[3] largely because they did not want to feel responsible for patients' deaths, especially the death of individuals who had fought so hard and for so long against EPSs, hospitals, and pharmacies. Under these circumstances, reducing therapeutic efforts and wasting away from diseases like cancer become justifiable only when biological life has been exhausted and taken to the limits of possibility.

Instead of calling for more effective strategies to diagnose and treat cancer early,[4] or mentioning the importance of guaranteeing equitable and prompt access to anti-cancer treatments, dismantling EPSs, and protecting the rights to life and health of all Colombians—all of which are much needed interventions—I end this book with a different kind of proposal. I envision the epilogue as an opportunity to participate in new exploratory attempts at "softening" cancer care paradoxes and composing newly arranged spaces in which to live on our way to dying.

Doctor R. M. Rajagopal is my muse. He is the pioneer of the palliative care movement in India and a Nobel Peace Prize nominee in 2018. During conversations I had with him in 2009, when I was still in the first years of my PhD program, the physician alluded to his medical practice as being "high-touch." According to him, this is a simple, low-cost, yet effective medical approach for patients who are in physical and emotional distress while also being a powerful practice for counteracting the disease-oriented medical paradigm. By engaging in a high-touch approach—sitting next to patients (and their family members), listening to them, caressing their dying bodies, and administering low-cost oral morphine—he and his medical team in Kerala, South India, have been providing comfort and symptom control for low-income cancer patients at the end of life. Their work has shown that simple and low-cost interventions can have profound effects on patients' quality of life. "In palliative care," he explained to me, "we do *touch* patients a lot, as human touch does have a therapeutic effect on the human being. In palliative care that *touch* symbolizes humanity. It is about managing pain, healing emotions, and lessening suffering."

Similarly, seeking to counteract the perverse effects of a neoliberalized health care system and the ethics of exhaustion, I argue, is not only about improving access to medical services that enhance and prolong life, as the current health care reform aspires to do. It is about having alternatives beyond fighting for the right to receive care ("sin tropel no hay salud") but also to *refuse* it. Hence the proposal to understand cancer not only as a defect, but as a condition that we may have to live with and die from. My hope for those who choose to continue getting aggressive and out-of-sync treatments and engaging in ever-present tropel is that their decision does not respond to the fear of the painful and disfiguring consequences of diseases like cancer.

Clinical studies have shown the effects of therapeutic touch and palliative care on cancer patients (Tabatabaee et al. 2016; Gentile et al. 2021). In 2010, for instance, a group of researchers led by Jennifer Temel found that patients with terminal lung cancer who transition to palliative care immediately upon diagnosis not only were happier, more mobile, and in less pain as the end neared; they also lived nearly three months longer than patients who underwent aggressive chemotherapy. Although this study could not determine why the patients lived longer, the authors and other experts had several theories: depression is known to shorten life, and patients whose pain is treated often sleep better, eat better, and talk more with relatives.

Furthermore, introducing palliative care earlier, even when curative measures are ongoing, may reduce hospital and emergency room costs. This means reducing patients' unnecessary visits to the hospital, so it may be cost-beneficial for both patients and insurance companies. If patients' symptoms are controlled, they (and their family members) won't feel the need to rush into an emergency room where they will be treated through invasive and aggressive biomedical protocols.

Yet the mere act of *slowing down* may be counterintuitive in the context of voracious diseases like cancer. Even though most major hospitals in cities like Cali have palliative care units,[5] the transition from oncology to palliative medicine is often difficult, let alone attempts at integrating these two approaches in standard cancer care. While low-income patients struggle to access expensive and uncertain treatments that may be out of sync with the time of cancer and the decaying conditions of their bodies, they simultaneously struggle to get palliative care services, not because these are necessarily expensive, but because they often are, paradoxically, low-cost.

A fully integrated "high-touch" palliative care approach may help patients who are systematically confronted with the double bind of a disease of self-devouring growth (Livingston 2019), on the one hand, and an economy of unlimited growth, on the other. It may offer an alternative for many of us who have ever been (or will be) caught up in the dilemma of getting heroic/aggressive treatments that may kill us but that are presented as the only solution or refusing these interventions just to face prolonged and painful deaths. Dr. Rajagopal's high-touch approach has enormous potential for "softening" the seemingly unresolvable paradoxes of cancer care in Colombia (and elsewhere), where the legal, bureaucratic, and financial practices created to guarantee access to anti-cancer treatments reproduce the same problems they were created to solve in the first place.

Admitting the inevitability of cancer deaths may help make this disease "livable and dieable." After all, as Jain (2013, 223) has written, "cancer has to be okay for people who are dying." Conversely, I would add, dying must also be rendered more thinkable and visible as part of our own therapeutic journeys. It is by "lathering" our ideas and assumptions about it, or "taking them up again over time from various perspectives and thus lending them consistency" (Solhdju 2021, 127), that a thickness of their own may eventually be possible.

Here I draw inspiration from the powerful story of Alice Rivières, who in 2006 took a genetic test that foretold she would eventually develop Huntington's disease. In her first-person account of the revelation of her test results, Rivières (2021, 31) shared her multiple encounters with the biomedical sphere and its "power to transform humans into medically conforming creatures." Her test results pushed her into a double bind: disease, on the one hand; medicine, on the other. Feeling unable to disentangle herself from biomedicine's overwhelming labeling process and singular forms of truth, it occurred to Rivières that suicide was "the only alternative with enough power, counterpoint, and emancipatory freedom" (34). Even though her anguish would later unfold into what she now calls "neurorevolutionary metamorphosis," as well as the starting point for the Dingdingdong project—a collective dedicated to coproducing knowledge about Huntington's and pushing thinking further—I want to pause and highlight her initial rumination about suicide.

Her seeming despair, I believe, could be used as an excuse for considering the healing and emancipatory potential of euthanasia—a kind of suicide, with assisted dying being one of its most common iterations in Colombia. This is a medical practice that hastens the death of a person "at the person's request, by means of an easy, painless and peaceful passing" (Mendoza-Villa and Herrera-Morales 2016, 326).[6] While legal in Colombia since 1997, euthanasia was thrown into legal limbo until 2015, when the Supreme Court asked the Ministry of Health to create much-needed guidelines for petitioning, assessing, and performing euthanasia. To date, however, euthanasia remains largely available to well-off patients who have the means and social capital to bypass the highly bureaucratic guidelines set by the government.

Inspired by Mara Buchbinder's *Scripting Death* (2021), I am not suggesting that euthanasia should be transformed into the default public policy for cancer patients who have metastatic diseases and who are often caught in exhausting tropel. This would be an oversimplistic and perverse rationale, to say the least, which would imply that it is easier to just die from cancer than to attempt to fix a dysfunctional health care system. It is worrisome that precarious living conditions and institutionalized systems of exclusion may bring terminally ill patients to the point where they wish to die. Rather, my intent is to consider practices of care at the end of life, especially for people who do not consider life as biological deterioration or who have been caught between incurable diseases and aggressive treatments. And, of course, guardrails must be kept in place to avoid the abuse of pressure on doctors or families to end lives prematurely from insurance companies eager to reduce expenses. Without such protections, it is not difficult to imagine whose deaths would be financially justifiable.[7]

I want to be clear. There are useful aspects of biomedicine and the health care system currently in place in Colombia. Both have saved many of our lives and improved the lives of people that you and I love, after all. In this book I have sought to present a reality in which many of us are dependent on these systems, even as we simultaneously try to build alternatives to them. Current government efforts directed at promulgating national health care reform are complex endeavors, rife with contradictions. And we must be prepared to run into deeply held assumptions—blind spots—that will need to be questioned, exposed, and dissolved. By responding to Rivières's (2021) call to use her Huntington's disease to push thinking further, my hope is that the paradoxes of cancer care described in this book will help us explore and facilitate conversations about emancipatory practices for living on our way to dying, and, to the degree possible, to dying with one's dignity intact.

NOTES

INTRODUCTION

1. In his book *Health in Ruins* (2002), the Colombian anthropologist César Abadía-Barrero describes how this destruction unfolded at a maternity hospital in Bogota.

2. In 2015, Ley Estatutaria en Salud (LES) 1751, or Statutory Health Law, was promulgated.

3. Almost simultaneously, in 2012, Santos began peace negotiations with the guerrilla group Fuerzas Armadas Revolucionarias de Colombia (FARC) at Havana, Cuba, which concluded in 2016 with a peace agreement between the Colombian government and the FARC.

4. Today 99.6% of Colombians are currently covered under one of the two mandatory insurance regimens (Ministerio de Salud y Protección Social 2022).

5. As Stengers (2023, 182) describes in a later book, the concept "ecology" points at "the creation of a local articulation between divergent interests, an articulation of heterogeneities that remain heterogeneous, that links without unifying, that composes without subjecting the terms that enter into composition with each other to a common interest."

6. See Betti Marenko's article "Stacking Complexities" (2021).

7. "Third-level," or tertiary care, hospital is a classification used for medical institutions that have the infrastructure, technology, and medical expertise to treat highly complex cases, from neurological interventions and open-heart surgeries to cancer and organ transplants.

8. More recently, Valle del Lili became a university hospital after partnering with ICESI, a private institution typically associated with wealthier *caleños*.

9. Colombia's southwestern region is a vast territory comprising eight states (known as departments) that occupies an area of more than 328,000 square kilometers (28% of the total area of the country), and has a population of nearly 12.3 million (25% of the total population of the country) (Zuluaga et al. 2017).

10. Cancer is typically classified by stages, 0 to IV, based on the main tumor size, the number of nearby lymph nodes affected, and whether the cancer has metastasized to distant

organs or tissues. The higher the number, the larger the tumor or the more it has grown into nearby tissues.

Prostate cancer is the second most diagnosed cancer and the fifth leading cause of cancer death among men worldwide (Sung et al. 2020; Wang et al. 2022). However, it tends to be one of the most curable malignancies if caught in its early stages and is typically characterized by slow growth or indolence.

11. Cisplatin is a chemotherapy drug that is not usually considered a first-line treatment for prostate cancer. However, it is sometimes prescribed for metastatic prostate cancers, especially for patients who have exhausted all other treatment options (Schmid, Omlin, Higano et al. 2020).

12. Before his tumor's biochemistry undergoes drastic changes that would make the cisplatin less effective.

13. Ciudad Córdoba is part of Agua Blanca district, a low-income neighborhood in eastern Cali that for decades has been the destination of displaced populations (largely from the Pacific region), many seeking to escape the violence and poverty that have stricken their territories.

14. Analogous to Rebecca Martínez's (2018) discussion of the high death rates for cervical cancer in Venezuela during the 1990s, one of the great tragedies of prostate cancer in neoliberal Colombia is the high mortality rate for a disease that is largely preventable and curable and has the potential to be transformed into a chronic condition. The highest rates of prostate cancer deaths are found in Valle del Cauca and the Colombian Pacific coast—part of the southwest region (Poveda et al. 2014). In 2020, the Global Cancer Observatory ranked prostate cancer as the most common cancer for males in Colombia (Sung et al. 2021). According to the Cancer Registry of Cali, prostate cancer is ranked first in mortality rates. See Cali's rates for prostate cancer at http://rpcc.univalle.edu.co/.

15. Through a public fund known as FOSYGA, Fondo de Solidaridad y Garantía, the Colombian state used to manage and distribute monies destined to cover health care services. In 2017, FOSYGA became Adres, Administradora de Recursos de la Salud, or Health Resources Management.

16. This fact may help explain why the national health care system was once ranked—in a highly controversial analysis informed by neoliberal ideologies—as one of the world's best and most financially equitable (Hernández 2002, 992; see also WHO 2000a).

17. The subsidized regime covers approximately 24 million enrollees, nearly 48% of the total market (Ministerio de Salud y Protección Social 2020).

18. Chapter 3 explores how medicina prepagada shapes medical practice.

19. In other parts of the Global South, similar frustrating experiences have been observed in the biomedical treatment of cancer (Livingston 2012; Mulemi 2017; Caduff et al. 2018; Martínez 2018; Banerjee 2020; Mika 2021; Van Hollen 2022; Bennett and Manderson 2023). For insightful anthropological works on waiting, see Dwyer (2009) and Hage (2009).

20. The hopes and expectations that always remain unfulfilled can also be analyzed via Lauren Berlant's (2011) concept of cruel optimism. Inspired by Berlant, Ruth Prince (2023) wrote an excellent article on cancer and health insurance in Kenya.

21. The subsidized regime for the poor or unemployed, the contributive regime for the working population, and the prepaid insurance as an out-of-pocket add-on for the wealthiest.

22. Sometimes terminal cancer is called metastatic cancer, but the two aren't always the same thing (American Cancer Society 2020).

23. Cooper provided generous feedback on earlier iterations of this book.

24. It is the most common legal action used by Colombians to protect their constitutional rights. Of the writs initiated by Colombians between 1999 and 2005, 30% asked to grant the right to health specifically (Defensoría del Pueblo 2014). Right to health writs are increasing every year, both in numbers and as a percentage of total writs.

25. Where patients often organize Go Fund Me campaigns and informal insurance practices to pay for medical services (see Gaviria 2020).

26. In 1991 the Colombian Constitution referred to health indirectly as a right. It meant that the protection of health was contingent on whether it had a relation with other rights that were considered fundamental at that time. In other words, if a patient's life was threatened because they could not access their prescribed treatments, then their health becomes fundamental and, therefore, a right protected by the state. This approach was known as the *derecho por conectividad*, or connectivity right (Cárdenas 2013).

27. In 2015 the Constitutional Court confirmed the fundamental aspect of health and established that this right should be protected via tutela whenever it is threatened (Pretelt 2017).

28. Today it is called Plan de Beneficios de Salud (PBS), or Health Benefits Plan.

29. After many political and judicial debates in light of the 1991 Constitution, Colombia passed a statutory law in 2015 (Ley 1751) recognizing the constitutional right to health. This law, according to Arrieta-Gómez (2018), was the result of the clash between two different perspectives: health as a fundamental right that is enforceable by the courts and health as a social right that should instead be addressed through public policies set by the legislative and executive branches.

30. Marisol de la Cadena (2014, 2015, 2021), with Strathern (1991), uses this expression to suggest that the order of things may be other than what and how we know it is. For Jhon Law (2004), "not only" has the potential for displacing "either/or."

31. In chapter 2, I explore how the tutela becomes a desirable route, not only for cancer patients who struggle to access high-cost services on time, but for EPSs that are on the verge of bankruptcy. When patients sue their EPS for not providing medical services due to "unjustified" treatment costs, the tutela allows them to transfer the financial responsibility to the state. In other words, once a tutela is ruled in favor of a patient, the state takes over the health care relationship and reimburses the EPS for the same treatment this business was hesitant to provide.

32. This dynamic "requires conceptualizing the pragmatic that the popular classes deploy to adapt to, while also derailing, the unidimensionality of the neoliberal competitive norm, to complicate it and combine it with other practices and knowledges" (Gago 2017, 3).

33. I am inspired by Stengers's (2023) reference to Leibniz, a mathematician and diplomat who knew the difference between submitting and being obligated. As a mathematician, Stengers writes, Leibniz was obligated by the concepts that practitioners like him have rendered possible. But at the same time, Leibniz was s diplomat because he was aware of his indebtedness to these mathematical concepts. As a result, he never contradicted his multiple correspondents but rather created "a translation of what they forcefully claimed, which would—if they accepted it—make a possibility for peace exist where a logic of war prevailed" (186).

34. These relations adopt pharmakon-like qualities, becoming both poison and remedy for cancer patients like Jairo. The Greek word *pharmakon* has two opposite meanings: “cure” and “poison.” This concept, according to Derrida (1981), produces a tension of binary oppositions fundamental to the Euro-American tradition: remedy/poison, good/bad, interior/exterior, etc. In other words, this concept signals a paradox that can be translated as “drug,” which means both “remedy” and “poison.”

Karen Barad’s (2007) notion of *intra-activity* may be another useful tool for thinking about such configurations. In contrast to interactions, which suggest connections between independent entities, *intra-actions* draw attention to the inseparability of individual entities.

35. “Subsidized growth,” following Dan Mains’s (n.d.) latest work in Oklahoma, describes how capital uses publicly funded infrastructure to support incessant growth in this state. In other words, the state intervenes to create the conditions in which growth is possible.

36. The same period during which neoliberal policies were initially implemented in Colombia.

37. Derrida’s (1994) notion of hauntology describes the paradoxical existence of a specter as neither being nor non-being, neither present nor absent.

38. See more examples of this simultaneity in chaps. 3 and 4.

39. A self-devouring growth is a cancerous model. According to Livingston (2019, 5), this form of growth operates “under an imperative—*grow or die; grow or be eaten*—with an implicit assumption that this growth is predicated on inhibited consumption” (original emphasis).

40. Except when viruses (e.g., HPV) and bacteria (e.g., *Helicobacter pylori*) are associated with the onset of certain kind of cancers, such as cervical and gastric malignancies, respectively.

41. This term refers to cells that are in their “original place” or have not yet undergone metastasis.

42. There are other kinds of drugs, such as targeted therapy, hormone therapy, and immunotherapy.

43. The links between chronic stress and several types of cancer (colorectal, breast, etc.) are becoming increasingly more solid.

44. I am indebted to Ramon Abel Castaño for challenging me to think more carefully about the health care crisis.

45. Castaño (2023) refers to “virtuous actions” as practices by which long-term investments—comprehensive primary care services, prevention campaigns, prompt access to medical services—are aligned with their short-term financial requirements, such as paying hospital bills on time or growing their market share. In other words, “virtuous actions” refer to insurance companies that invest in the future by preventing and curing cancer in the present.

46. In 2000, WHO ranked the national health care system as one of the “best” in the Americas in overall performance and fairness in financial contribution, measured as households’ contribution to the system’s financing (WHO 2000a; Tandon, Murray, et al. n.d).

47. The government created a formulary called Plan Obligatorio de Salud (POS), or Mandatory Health Plan, which includes all the authorized treatments and drugs that EPS must provide. Exclusions are mostly cosmetic practices and expensive drugs that have generic equivalents on the market. Recently the POS was renamed Plan de Beneficios en Salud, or Health Benefits Plan.

48. According to my dictionary definition, *coexistence* is merely the state or fact of living or existing at the same time or in the same place. *Cohabitation* refers to a form of coexistence in which interaction and intimacy are defining aspects of what it means to exist at the same time or place.

49. Consider a more recent example. In July 2022, the Centro de Tratamiento e Investigación sobre el Cáncer (CTIC; Center for Cancer Treatment and Research) opened its doors in Bogotá. CTIC is a cutting-edge and nonprofit private hospital funded by a Colombian entrepreneur and philanthropist, Luis Carlos Sarmiento Angulo, who invested nearly US $400 million in its construction. The CTIC has several radiotherapy bunkers, more than 9 surgery rooms, 56 infusion ports, and 174 hospital rooms, of which 30 are reserved for intensive care. From its inception, the national government declared it a Proyecto de Interés Nacional Estratégico, or Strategic National Interest Project (Portafolio 2022). In line with Sarmiento's philanthropic and modernizing goals, he made sure his investment—and its cutting-edge technology—will be available for all Colombians, regardless of their health insurance regimes and socioeconomic status. However, access to hospitals like CTIC boils down, in part, to patients' EPSs and these businesses' pledge to pay on time.

50. Influenced by European colonial rationales (see Hegel 2004), Latin American elites have assumed that development and progress are more likely to encounter the "right" conditions in temperate places like Bogotá than in the torrid and humid jungles of the southwestern territories. As such, Colombian elites (typically from cities like Bogotá that are nestled high in the Andean plateau) have referred to the southwestern territories as waste land, mostly inhabited by "backward" Indigenous and Black populations (Tirado Mejía 2022). In neighboring Venezuela too, the management of poor populations and the implementation of the project of modernity have been informed by this rationale (Coronil 1997; Martínez 2018).

51. It is important to note that metastatic cancer is not a definitive sign of imminent death. Patients can still live decades with metastatic cancer with the right treatments. Yet not all metastases are created equal. A stomach cancer with metastasis to the pancreas, for instance, will most likely kill patients faster than a prostate cancer with bone metastasis.

52. I was born in Bogotá, the capital of Colombia, but grew up in Peru and Bolivia. In the early 2000s I returned to Bogotá to complete my bachelor's degree in anthropology, before moving to the United States for graduate school in 2007.

INTERIM I: UPDATE ON THE LATEST HEALTH CARE REFORM PROJECT

1. Financial and intermediary roles would be transferred to Adres.

2. Health economists and public health experts would agree that there is no "perfect" health care system. Any given choice in the structuring of the system would necessarily involve a trade-off (Castaño 2023).

1. OUT-OF-SYNC CANCER CARE

1. *Mami* is a popular word I came across in Cali. It was frequently used by male patients when they interacted with female interlocutors. *Mami* is the diminutive of "mamá" or "mother." *Mamá* was often used interchangeably with *mami*.

2. For insightful anthropological works on cancer and time in the Global South, see Noémi Tousignant's *Untimely Liver Cancer and the Temporalities of Care in Rural Senegal* (2023).

3. Protocols, for Berg (1998), are sequenced algorithms or paths of action that tell physicians how/when to act and bring order to messiness in biomedical practice.

4. Scholarship at the interface of studies of narrative (Brooks 1984; Ricoeur 1984) and medical anthropology (Good et al. 1994; Mattingly 1994, 1998) offers a useful language to analyze how the scientific robustness of clinical medicine protocols and plans for action structures clinical time, instills desire for treatment, and gives hope to patients, their families, and their attendant physicians (see also Good 2007). In the case of most low-income cancer patients in Colombia, however, these therapeutic courses emerge through frustrating vueltas that Kafka would have envied.

5. This model is based on two insurance regimens, one for the poor and unemployed and one for working individuals who make more than two minimum wages. Prepaid insurance exists as an add-on for wealthier patients who can pay for premiums out of pocket (see introduction).

6. In *World Health Organization* (2019), Marcos Cueto and colleagues offer a comprehensive historical analysis of this phenomenon.

7. In 2018, however, Andrés Manuel López Obrador undertook a structural transformation of the national health care system. The main goal was to move towards a centralized system that curbs corruption and limits out-of-pocket expenses (see Singer 2022).

8. Costa Rica has kept the public funding and administration of the original system, with universal insurance (a tutela-like system), introducing competitive mechanisms that sought to improve efficiency and the equity of the services. This country has shown important results in terms of equity, according to Barr and Marmot (2021).

9. In 2022, for instance, there were 24,399,839 individuals enrolled in the contributive regime and 24,745,934 in the subsidized regime (Ministerio de Salud y Protección Social 2022).

10. In 2023, several small to midsize banks in the US collapsed when many of their depositors withdrew their savings in response to increasing fears of a global recession.

11. During the early days of the COVID-19 pandemic, for instance, health insurance premiums in the US skyrocketed due to the high number of people falling sick with the virus and being hospitalized.

12. In 2022, according to the Ministry of Health's decree 2381 of December 2021, the UPC was roughly 927,000 pesos for the subsidized regime.

13. In the context of COVID-19, a similar logic applies with respect to time and the need for containing the disease. When the pandemic began, the use of masks was encouraged to slow the rate of spread and limit patients' visits to overwhelmed hospitals. The rationale was not prevention altogether but modulation of the pace at which hospitals would admit patients into their already overcrowded ICUs.

14. It is important to mention the historical imbrication of biomedicine with capitalism, particularly in Latin America. The Rockefeller Foundation, for instance, and major multinational companies in the region were at the forefront of mainstreaming biomedicine to promote worker health/company profits in the early decades of biomedical ascendancy (see Cueto 1994).

15. See Vargas (2022) on the uninsured in Chicago.

16. The US is an exception in the Global North in terms of health care access. Whereas Canada and most of northern and western Europe have socialized medicine, the US does not; rather it has an extremely complicated insurance-based system for accessing health care. The way the Affordable Care Act, or Obamacare, has been operationalized is similar to Colombia's model, even though in the US health care is not a right. For the uninsured or underinsured or those who otherwise have limited access to health care, the health care relationship also determines delays in treatment seeking and long delays in getting cancer treatments approved, if they are ever approved (Siegel, Miller, and Jemal 2015).

17. While the idea that the market is somehow opposed to and independent of government has been central to justifying laissez-faire. According to Graeber (2015) economic policies designed to lessen the role of government have rarely achieved such a goal. English liberalism, he further explains, did not lead to a reduction in state bureaucracy but the exact opposite.

18. This is the illusion of "having a mother—but dead" (see introduction).

19. In Colombia, there is the sense that corruption and impunity in insurance companies violate the right to health of its citizens. Various scandals point to legal processes that are supposedly advancing while the owners and directors of insurance companies caught denying care and embezzlement continue to be free, enjoying their fortunes and expanding their profits. One emblematic case was that of SaludCoop EPS, an insurance company that experienced dramatic growth between the 1990s and the mid-2000s. Local journalists and researchers documented its rise from a small insurance company to a huge multinational, offering a highly diversified portfolio of services and investing millions of dollars in the financial market in the Dominican Republic, Chile, Ecuador, and Mexico (Vélez 2016). It also had investments in soccer teams, golf courses, schools, and real estate in Panama.

20. See the introduction for a discussion of this concept.

2. ORDINARY CRISIS

1. Nueva EPS, for instance, was created in 2008.

2. This is a wide-ranging effort to counteract the inequalities and social injustice unleashed by the market-driven health care system implemented in 1993.

3. During 2011–13, the possibility of a radical transformation of the health care system was perceived as highly improbable. It would not be until 2023 when a radical reform project was filed in Congress.

4. Estratos is a ubiquitous system of socioeconomic classification in Colombia that ultimately determines who has higher chances for living longer or dying sooner.

5. This reasoning reminds me of the concept of residual inequities mentioned by Ramon Abel Castaño (2023), which refers to inequities—associated with social determinants of health, for instance—that have proven extremely difficult to address by most health care systems.

6. Until 2008, health was not considered an autonomous right, unless it was connected to life (*derecho por conexidad*, or the right of connectivity).

7. My colleague Misha Klein provided the inspiration for the head of this section.

8. This seems to be a wider tendency common to places like the US. A recent article published in the *New York Times* reported that pediatric centers have been closing their doors because medical services for children do not produce the same level of profit that treatments for adults who suffer from with chronic conditions do (Stockton and King 2023).

9. Roughly US$3,000 at the time.

10. Caprecom EPS was one example.

11. See chapter 1.

12. See chapter 1 for a discussion about treatment deferrals.

13. In 2009, for instance, the Boston Consulting Group considered SaludCoop EPS one of the five Colombian multinationals that were part of the top 100 enterprises in Latin America. In ten years, the small cooperative group had multiplied its capital almost 100% and acquired other EPSs.

14. In 2023, for instance, the overall budget for the health care system (both the contributive and subsidized regimes) was more than 50 billion pesos (Congreso de la República de Colombia 2022).

15. See chapter 1 and the introduction.

16. See chapter 4 for a discussion of brand-name oncology drugs and tutelas.

17. Through a controversial move in early 2020, the Ministry of Health derogated the mechanism of recobro (Decrees 205 and 206). In doing so, the government sought to accomplish three main goals: (1) to provide EPSs with more funds by streamlining the process through which No-POS medications were accessed by patients; (2) render more transparency and accountability in the management of these funds; and (3) reduce the number of tutelas filed to access medical services, thereby eliminating congestion in courthouses.

18. It has been renamed Adres. This is a public fund under the aegis of the Ministry of Health, which manages and oversees the financial resources of the national health care system.

3. MALIGNANT YET BENIGN

1. Nevi are the most common type of moles. They are benign by definition. However, around 30% of malignant melanomas arise from preexisting nevi (American Academy of Dermatology 2022).

2. On clinical uncertainty, see Livingston (2012); Jain (2013); Sarradon-Eck (2015); Nelson (2016). On biomedicine and capital, see Sunder Rajan (2006, 2012, 2017); Cooper (2008); Dumit (2012).

3. "When Runa defines the position of the subject, this subject is not only human. Similarly, when Tirakuna occupy the position of the subject, they are not only human" (de la Cadena 2014, 256). The fact that they occur at the same time within the Ayllu means that one cannot exist without the other.

4. Ganglia are part of the body's defense mechanism and usually catch and eliminate foreign agents. In the context of cancer, swollen ganglia are often associated with metastases.

5. ABCDE diagnostic criteria are based on moles' form, contour, color, and size.

6. Latour's (1987) "machine's internal complexity." When theories reach a certain point of acceptance, they begin to be treated as true, as being a black box rather than a theory.

7. This reminds me of Katrin Solhdju's (2021) discussion about "speculative narration," which is a creative practice that seeks to contrast "predetermined" paths with accounts of how things could be otherwise.

8. Recall that Dr. Rayo only excised a tiny sample from the mole in the first biopsy.

9. While the dysplastic nevus diagnosis did not eliminate the possibility of having cancer, Juana chose this benign probability and embodied her nevus with full confidence, ruling out the need for tumor and lymph node excisions. This is where Juana's clinical story ended and my intellectual inquiry began.

4. BRANDED TIME

I thank my colleague Elyse Ona Singer for the title of the chapter.

1. Homedes and Ugalde (2005) have discussed how the meanings of generic and branded products vary across Latin America. In Colombia, they explained, the term "generic" is used to indicate that the pharmaceutical product is nonproprietary and is equivalent to the brand-name product. Products with nonproprietary names are off-patent. In this chapter I understand branded drugs as original products, which may be on patent or off patent. On the other hand, generics refer to nonpropietary, off-patent products that have the same molecule as equivalent brand-names.

2. A 2012 Health Policy and Planning study, for instance, found large price variations among Latin American countries. This study blamed the discrepancies, in part, on the lack of transparency in setting prices in different countries (Wirtz, Santa-Ana-Tellez, et al. 2012). In 2018, Álvarez y González conducted a comparative study of Latin American countries in which they listed drug prices from the cheapest to the most expensive. Not surprisingly, Colombia ranked as one of the most expensive. The cheapest markets for innovative or newer drugs were Argentina and Peru; generics and branded generics turned out to be less expensive in Mexico and Argentina; and pure generics were less expensive in Peru and Chile (Álvarez y González 2018).

3. While EPSs were initially created as health insurers that manage risk and oversee health care expenditure, many of these businesses have engaged in vertical integration. This is a profitable and cost-saving arrangement in which the supply chain of a company is integrated and owned by that company. EPSs, for instance, have invested in (or fully acquired) hospitals, labs and diagnostic technologies, medical supplies, pharmacies, etc.

4. For a thorough analysis of the market in generics in Mexico, see Cori Hayden's latest book, *The Spectacular Generic* (2023).

5. A bultero is one who makes a living lifting *bultos*, heavy cargo or packages, on their back.

6. Abiraterone is one of a group of medications called androgen biosynthesis inhibitors.

7. In 2012, a box of 500 mg was around 100,000 Colombian pesos (US$30).

8. Nonsteroidal antiandrogen medication that is often used in the treatment of prostate cancer.

9. From citarabin and doxorubicin to mercaptopurin and epirrubicin, drug availability has been a common issue for many essential generics used in the treatment of cancer.

10. See the introduction and chapter 1 for more on the two EPS regimes.

11. These explicit differences may have partly reinforced my interviewees' perceptions about generics as drugs of "lower" quality, typically prescribed to poor patients.

12. Between 2011 and 2013, for instance, an average of 110,000 tutelas per year were filed against EPSs to protect the right to health (Corte Constitucional 2018). Of these tutelas, around 33,000 (30%) were filed to request access to No-POS medications (Defensoría del Pueblo 2022).

13. Apart from No-POS expenditure on brand-name drugs, there is also a considerable expenditure on social services such as diapers for older adults (Gaviria 2014).

14. One famous example is Gleevec, an anti-cancer drug produced by Novartis. In 2016 Novartis was accused of overcharging for this drug. A legal battle ensued against the Colombian government, which sought to unilaterally lower its price by 45%, arguing the drug was incompatible with the local economic reality. Abusive cases like this are not new in Colombia and elsewhere. Novartis itself has a history of overcharging for drugs such as Exforge and Diovan (for high blood pressure) and Tegretol (for seizures) (Silverman 2016).

15. In 2012, Colombia introduced one of its most comprehensive pharmaceutical policies. Even though this is not the first in the country, it is known for emphasizing the relation between drug access and the fundamental right to health, on the one hand, and drug expenditures, on the other hand (Andia 2018).

16. "There are two different institutions involved in pharmaceutical price regulation. The Comisión Nacional de Precios de Medicamentos y Dispositivos Médicos (CNPMDM), an interministerial commission, . . . oversees the design of the methodology whereby drug prices are to be regulated . . . [and] the Ministry of Health, which is responsible for implementing price regulation" (Prada et al. 2018, 2).

17. Even though ERP has the potential to reduce the cost of pharmaceuticals, it could paradoxically lead to a surge in the demand for these regulated items (Prada et al. 2018).

18. In response to price control measures, pharmaceutical companies have tended to diversify their portfolios into regulated markets and unregulated markets (Prada et al. 2018).

19. "After price control measures were put in place in Colombia, drug prices decreased about 43%, while real pharmaceutical health expenditure almost doubled" (Prada et al. 2018, 5).

20. POS benefits are updated every two years, largely by including new medical technologies. In 2014, for instance, the list included more than 500 medical procedures and 660 generic drugs that EPSs must provide. "Between 2012 and 2017 there were 183 new technologies included in the POS, the majority of which were being used to treat high-cost diseases such as cancer, arthritis and multiple sclerosis" (Andia 2018, 34).

21. This law reaffirmed health as a fundamental right and set the juridical rules and mechanisms to protect it.

22. A good reason for that, according to Prada and colleagues (2018, 2), "is that No-POS expenditure is mainly for new technologies for high-cost diagnoses such as Cancer, Arthritis, HIV, rare diseases and organ transplants."

23. See the introduction for a conceptualization of neoliberalism in Colombia. There is a body of work that has explored how state and market get intertwined under neoliberalism (Mains 2012; Gago 2014; Hayden 2023).

24. Unlike their colleagues who spend their time at private hospitals, reps at HUV seemed to enjoy privileged access to a variety of spaces. From waiting rooms and medical offices to emergency hallways and in-patient wards, reps seemed to be a ubiquitous presence throughout the hospital.

25. I noticed a disproportionately large number of female reps at HUV.

26. Doctors I worked with often mentioned that hospital pharmacies scan patients' prescriptions and relay them to pharma companies.

27. These ethical guidelines have been developed by the Pharmaceutical Research Labs Association, or Asociación de Laboratorios Farmacéuticos de Investigación (AFIDRO). According to its website, AFIDRO is a private, nonprofit trade organization that promotes research, development, production, and marketing of quality pharmaceutical products in Colombia.

28. See Sismondo (2018) for a discussion about the politics of pharmaceutical knowledge production.

29. Often sample medications are not novel or useful and may be expired or inappropriately used by physicians and staff members (Evans and Brown 2012). In the US, sample medications are more commonly used by patients who have health insurance (Cutrona et al. 2008). Brown (2021, 348) states, "A patient started on an expensive brand-name drug is more likely to continue that drug." In this country, free drug samples constitute a large portion of pharmaceutical companies' marketing budgets. Between 1996 and 2000, slightly more than half of all dollars spent by the pharmaceutical industry went toward promotion (Rosenthal et al. 2002).

30. See Praspaliauskiene (2022) for a more extensive discussion of enveloped care.

31. This would have been described by Dr. Masa as Cantinflaesque policies.

32. A Peruvian and Chilean alcoholic cocktail made of pisco (its base liquor), lemon juice, and egg whites, among other ingredients.

33. According to Greenblatt and Khaddour (2022), trastuzumab is typically used alone or with other drugs to treat breast, stomach, and gastroesophageal malignancies.

34. See Hayden's *Spectacular Generics* (2023) for an insightful discussion about *lo mismo pero diferente*, the same but different.

35. Sean Brotherton (2012) coins the term *sociolismo* in his ethnography on health care in Cuba. He uses it to describe a health care system where people navigate their health care needs between socialism and social ties.

36. Several oncologists I interviewed talked about six main groups of standard chemotherapy drugs. Each group has a list of up to twenty drugs that have similar chemical structures and modes of intervention. Drugs that belong to the same group, thus, are often interchangeable. Some medications, however, work in more than one way and may belong to more than one group (American Cancer Society 2019).

37. In his ethnographic work with dying patients in northern Thailand, the physician and anthropologist Scott Stonington (2020c) has written about these relations between locations, Buddhism, and ethics. He shows that for many people it is ethical to withdraw life support in the home but unethical to do it in the hospital. Hospitals and patients' homes, he contends, could be considered different ethical locations because each of these settings is defined by unique ethical frameworks governing decisions about life and death.

38. Physicians I met during my longest stretch of fieldwork agreed that there were roughly twenty oncologists in Cali, in a population of more than two million.

39. Even though Horacio managed to access multiple Zytiga dosages after filing a tutela, his prostate cancer was too advanced and did not respond to the treatment. He died six months after I had returned to California to begin writing my PhD dissertation.

40. By way of Biehl's (2007) pharmaceutizalization, the term "chemotherapization" refers to the ethics of giving everyone chemotherapy. While it will kill some patients and injure many, it will save others.

5. ETHICS OF EXHAUSTION

1. He had not received any prior hormone therapy to lower androgens in his body (e.g., testosterone). Decreasing androgen levels or stopping them from getting into prostate cancer cells often makes these malignancies shrink or grow more slowly for a time. Hormone therapy alone, however, does not cure prostate cancer.

2. This is one of the most common generic drugs used for prostate cancer, which is usually administered with steroids such as prednisone.

3. A type of nuclear radiology procedure by which a radioactive substance, called a tracer, is injected into the body to detect abnormal physical and chemical change.

4. Sometimes the docetaxel rechallenge could represent an alternative for other expensive drugs in countries with limited access to recently approved drugs.

5. A small town north of Cali.

6. In the case of a disease like cancer, protocols are usually provided by Global North organizations such as the US National Comprehensive Cancer Network (NCCN) or the National Institutes of Health (NIH).

7. These words were later confirmed by another physician, Ricardo Rueda Sáenz, a renowned Colombian OB-GYN who specializes in fertility issues. He explained to me that "a good doctor is someone who may be inside this 'box' but is also capable of looking/thinking outside of it. And while being outside, she can look inside the 'box,' engaging in both actions simultaneously" (personal communication).

8. Therefore, following Cazdyn (2012), they are "already dead."

9. For a discussion about tutelas, see the introduction and chapter 2.

10. In her book *Ordinary Medicine* (2015), Sharon Kaufman uses the term "ordinary" partly to describe how rare and risky procedures suddenly become routine for older patients in the US. To explore the reasons cancer patients in Colombia experience more pain and suffering, I borrow Kaufman's use of the term, for there is nothing inevitable about biomedical protocols by which more aggressive interventions become standardized and ethically appropriate. Drawing inspiration from Kaufman, the term "ethics of exhaustion" allows me to trace how counter-protocols in Colombian oncology may become ordinary for metastatic and terminal cancer patients, until life has been reduced to its bare minimum. It refers to medical practices as means for improving health and caring for patients but also being informed by the moral mandate for "wearing patients out" (Biehl 2012). The ethics of exhaustion, hence, reflects a rationale in which cancer care seems to be bounded by aggressive interventions and shaped by slow-walking transitions into palliative care—even when cancers are metastatic and terminal.

11. See Rivières (2021) for a first-person account of her frustrating experiences with testing for Huntington's disease.

12. See chapter 1 for a discussion of the concept of vueltas.

13. In chapter 4 I explore the relation between tutelas and the use of branded chemotherapy drugs.

14. See chapter 4 for an analysis of how senior oncologists manage their relationships with pharmaceutical reps and ask them for favors, such as free sample dosages of branded chemo drugs for their low-income patients.

15. Refer to Ian Whitmarsh's *Biomedical Ambivalence* (2008) for an exploration of the ambiguities that physicians juggle as they care for asthma patients in Barbados.

16. In his ethnographic work in Barbados, Whitmarsh (2008) explores how doctors enact and criticize the expansive diagnosis of asthma in the island. He argues that such ambiguities are central the efficacy and undermining of the global pharmaceutical industry.

17. An interdisciplinary medical approach to managing pain and suffering in the context of a chronic or terminal condition. See Twycross (2003).

18. Also known as hospital-acquired pneumonia, this is a lower respiratory infection commonly present at medical facilities.

19. Here, again, Sharon Kaufman (2015) is my muse.

20. In *Another Science is Possible* (2018), Stengers explores the implications of "speed" in the context of scientific production and makes a plea for slowing down. By slowing down how problems are formulated and "resolved," she contends, other kinds of thoughts and interventions may become imaginable and possible. Stengers writes in an earlier work, "Slowing down seeks to create an opening where 'a slightly different awareness of the problems and situations mobilizing us' can be aroused" (2005b, 994).

21. Lochlann Jain (2013) has warned that early screenings (or moving faster than cancer) may provide few benefits for people whose cancers would kill them anyway (especially those who cannot access medical services on time) and that these treatments have the potential to injure people who have very small malignant tumors.

22. I borrow this concept from the Nigerian novelist Chimamanda Ngozi Adichie.

EPILOGUE: EMANCIPATORY FUTURES

1. It might even be possible to argue that, based on the latest clinical research on the effects of chronic stress on our bodies (Yang et al. 2019; Dai et al. 2020), most of the situations endured by low-income cancer patients are carcinogenic in themselves. Evidence from laboratory studies suggests that chronic stress may cause cancer to get worse (progress) and spread (metastasize) (Androulidaki et al. 2009; Chang et al. 2016).

2. See chapter 5 for a discussion of the dilemmas faced by oncologists as they seek to treat metastatic and terminal cancer patients.

3. Chemo regimens that are considered too aggressive and may not yield beneficial results (see chapter 4).

4. There are incredibly complex financial, medical, and ethical challenges associated with these efforts.

5. A crucial palliative care law was passed in 2014 (Law 1733), also known as Ley Consuelo Davis Saavedra. It seeks to guarantee and regulate access to palliative care services

to patients suffering from terminal, chronic, or degenerative conditions and improve their quality of life through integral pain management.

6. During an assisted-dying procedure, a physician is present and administers the cocktail of anesthesiology drugs that makes patients unconscious, followed by an injection of muscle relaxants that stop their heart. Crucially, the presence of health care personnel during the provision of euthanasia reduces the risk of any potential mistakes resulting from the lack of assistance.

7. This is, perhaps, what makes the Colombian case unique and valuable for the standard North American bioethical discourse. While bioethics in the US has tended to become a modern form of medical ethics, in which the moral aspects of the relationship between patient and physician and its central value of individual liberty shapes the medical-legal discourse, in Colombia euthanasia revolves around a question of justice.

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