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CONSTRUCTING INEQUALITY IN THREE KENTUCKY COMMUNITIES: DISCOURSES OF BLAME AND RESPONSIBILITY

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ABSTRACT OF THESIS

CONSTRUCTING INEQUALITY IN THREE KENTUCKY COMMUNITIES: DISCOURSES OF BLAME AND RESPONSIBILITY

This thesis focuses on the social determinants of health in Appalachia. Using anthropological ethnographic field methods, this thesis explores the ways in which public assistance programs and exchanges between health care practitioners and clients result in discourses of blame and responsibly. Also included is a discussion of the role that health insurance plays in granting or denying individuals living in poverty the opportunity for treatment and care. The narratives collected for this project then become the bases for a critical examination of the public discourse surrounding health care reform in the United States in 2009 and 2010.

KEYWORDS: health inequalities, culture of poverty, public assistance, gender, Appalachia

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THESIS

Elizabeth J. New

The Graduate School
University of Kentucky
2010
CONSTRUCTING INEQUALITY IN THREE KENTUCKY COMMUNITIES:  
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THESIS

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts in the  
College of Arts and Sciences  
at the University of Kentucky

By

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2010

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Chapter 1

Introduction

The Appalachia portrayed in fiction and film is constructed through a series of conflicting images. One image of the mountains is peaceful and promising, a favored retreat for those wishing to escape the pressures of urban life. Another depicts the quickly vanishing natural landscape; raped and pillaged of its resources at the hands of greedy outsiders. Still a third version of Appalachia portrays mountain communities as dark and violent. In one way or another all these images are linked to the residents who inhabit the mountains. In the first scenario mountain residents are quaint and unassuming, living simple and uncomplicated lives. In the second they are in need of intervention; either because they are oblivious to or do not care about the environment being destroyed around them. The third version portrays mountain residents as bloodthirsty and lawless people, openly hostile to outsiders and each other. What ties all these images of Appalachian people together is the idea that they are in some way fundamentally different from other U.S. residents. Thus Appalachia and its residents become a symbol of what the United States once was and rather what it continues to be.

However there is an alternate Appalachia. This Appalachia contains ribbons of asphalt transporting eighteen wheelers and passenger cars over hills and through clear-cut valleys. Interstate 75, a six lane symbol of modernity, is a concrete division between two parts of Kentucky. On the interstate, Appalachia becomes a fully industrialized space, where blinking lights and construction create a constant flurry of activity and confusion. Smog replaces mist as the summer heat radiates off the
pavement. Signs posted by the roadside warn motorists not to litter, watch out for falling rocks, and be aware of animals attempting to cross. Gas stations, chain restaurants, and sub-divisions often take the place of family farms in this Appalachia. Billboards frequently obscure mountain views while simultaneously marketing mountain life to those who can afford it, if only for a weekend.

Appalachia as a place and an idea has fulfilled a number of purposes for US residents over the centuries. For some Appalachia is a place bounded by geography, for others it is an idea or memory connected to identity. Appalachia has served as a symbol for both fundamentalist conservativism and radical activism. However whether Appalachia is constructed as a literal or figurative space, it is a region that has had an important impact on the development of the United States. Appalachia has not only served as an important source of mineral resources for the country, but as a producer of low-wage labor as well (Eller 2008, Scott 1995). But what role does region play in the imagining of place in the United States? Douglas Powell argues the construction of region plays an important role in the social, political, and economic positioning of many American communities (Powell 2007). Several Appalachian communities, particularly those in Kentucky, have played an integral role in the way U.S. residents outside the region understand poverty. From the New Deal to the War on Poverty, Appalachian communities in Kentucky have come to symbolize persistent poverty in the United States in times of economic and political instability. However like other American landscapes, Appalachia is a fragmented space, influenced by multiple people and a diverse and divergent number of histories.
These contradictory images of Appalachia, the industrialized, the natural, and the hostile are commodified for the consumption of a privileged few. Although these images frequently manifest as a rigid dualism, each becomes an “authentic” representation of Appalachia in one way or another. Each of these versions of Appalachia has become meaningful, as the policies which accompany them have created social, political, and economic barriers for many mountain residents. However these same images have created opportunities for others. One popular discourse locates the origins of local inequality in power asymmetries created by outside intervention. Although the profit associated with Appalachia’s extractive industries do often disproportionally benefit individuals and groups living outside the region, local elites have also used these resources to accumulate personal wealth. This unbalanced distribution of power and resources then precipitates in the institutionalization of localized hegemonies. Powell (2007) uses the contradictory spaces found in one Appalachian community to illustrate how physical space is given social meaning. Social spaces located in wealthier parts of town and frequented by residents with more social influence are thought to be safer, cleaner, and more family friendly. Social spaces connected to impoverished populations are then linked to questionable social behavior such as drug use, violence, and casual sexual encounters. Powell then illustrates how local power hierarchies transform these tensions into a state-wide discourse on the community which are then used to pathologize the state or region to the nation.

While at times I draw on the work of Appalachian scholars, this text seeks to frame Appalachian communities as American communities, as opposed to isolated,
regionally specific spaces. Most of my respondents did not consciously refer to themselves as “Appalachian” and this could be linked to the predominantly urban communities where I conducted my field work and the personal backgrounds of my informants. However most of my informants did identify themselves, and others, by their county or community of residence. They made a clear distinction between “the city,” meaning Lexington, “town” which referred to the town closest to their current residence, and “the country,” “the county,” or “the mountains.” Their narratives frequently included discussions of marginalization which could be linked to larger discourses on regional inequality. Local landmarks, roads, and family names were also used to differentiate their social and political locations as well as explain their definitions of status, wealth, and poverty.

The initial goal of this project was to explore the repercussions of a clinic closing in Madison County. I was interested in why the clinic closed and what that meant for local residents in terms of access to health care facilities. I soon learned that the clinic closing was not the issue foremost in the minds of many residents and that their concerns for their health and well-being being extended far beyond access to medical facilities. Although I divided my lines of questioning into two categories, access to health care and health care decision making, I discovered these too were oversimplified approaches to the issues facing my informants. Ultimately this project evolved into study of the social determinants of health and how state-based public assistance programs and private health insurance companies influenced the choices that individuals living in three Kentucky counties made for themselves and their dependants. Many of the individuals I interviewed felt trapped in part-time, low-
wage occupations, while still others who were currently unemployed were struggling to secure living-wage jobs. They were also concerned about their personal and professional relationships and their children’s futures. Negative experiences with various forms of public assistance also framed many conversations, tying issues of marginalization and inequality to relationships formed at the local level. In many instances the women I interviewed did not think or talk about health in terms of illness, however many of their stories spoke to issues which have a direct and significant impact on their health.

To further my own theoretical argument, as well as continue to build on the body of literature which influences my academic perspective, I argue that although the communities where I conducted my fieldwork are located in the Appalachian region, they are not places removed from the rest of the United States. Nor are the residents in these communities experiencing constraints based solely on their geography or regional affiliation. Because social and economic constraints are intimately linked to health inequalities, I divided this ethnography into two distinct sections. The first section focuses on the relationship between persistent poverty and public assistance. This section features narratives tied to the stigma and constraint faced by women interacting with government subsidized programs such as workfare and Women, Infants, and Children (WIC). The second section focuses on the way health care professionals interpret their roles as care-givers, understand the needs of their clients and navigate bureaucratic barriers put in place by private health insurance companies. The arguments present in the following text are not designed to draw focus away from the very real issues of persistent poverty facing many rural communities in
eastern Kentucky. Instead I hope these narratives illustrate the diversity present in these Kentucky counties and demonstrate how social inequality is experienced and understood from a diverse segment of the population regardless of their social location or socio-economic status.

**Literature Review**

In the American imagination, what it means to be Appalachian is often connected to images of poverty and deprivation. The “othering” of Appalachian people is still frequently overlooked as a form of discrimination. From jokes depicting Appalachians as crude and illiterate, to government campaigns which reinforce stereotypes personifying Appalachia as a symbol of modern-day poverty, Appalachian people have become marked subjects constructed to represent the social pathologies of the white under class in the United States (Hartigan Jr. 2003).

Appalachia as both a physical and metaphorical space also plays an important role in the perpetuation of the American frontier; the origins of which can be linked to both adventure travel literature as well as the “local color” movement of the nineteenth century. William Goodell Frost, president of Berea College in the mid-nineteenth century also contributed to the idea that Appalachia was a place frozen in time by describing Appalachian residents as “contemporary ancestors” (Becker 1998:41). This metaphor helped reinforce the idea that both the region and the people who inhabited it were a byproduct of a lifestyle the rest of the nation had overcome or long forgotten. These images have been reinvented for new generations as media continues to change and television and movies reify damaging stereotypes with visceral imagery. Even in the twenty-first century, people from the mountain south
are portrayed as racist, uneducated, isolated, apprehensive, and hostile to both outside influence and modern intervention (Lewis 2004).

One way to begin to reconcile these images is to acknowledge that the history of inequality in Appalachia is part of a larger social history of inequality in the United States. In a nation where residents are socialized to believe hard work will ultimately produce success; a discourse of failure and blame is created around individuals who continue to struggle. In this culture of poverty model, those who encounter obstacles are not only portrayed as victims, but their poverty is presented as maladaptive or the result of regressive cultural practices (Billings 1974). Culture of poverty also ignores the role history plays in the creation and perpetuation of persistent poverty in the United States. Deconstructing historical patterns of marginalization in Appalachia offers an explanation for how and why mountain people have come to symbolize white poverty for an entire nation. A critical approach to regional studies not only confronts the construction of Appalachia as a homogeneous place both economically and socially, but challenges ideologies and institutions which reify culture of poverty.

Investigating the experiences of those participating in government sponsored public assistance programs is another way to critically examine institutional inequality in the United States. These programs are highly racialized and gendered, characterizing recipients as individuals who are unwilling to work (Mittelstadt 2005, Collins 2008). Rather than exploring reliance on public assistance from the perspective of institutional constraint, culture of poverty frames an individual’s reliance on public assistance as product of poor, irrational choices made at the personal level. This focus on choice subverts the racist and gendered
discrimination present in current social service programs. Women who are heads of households, women with small kin networks, or women with limited support systems are at higher risk to become integrated into the welfare system (DiFazio 2006). However while the pathologization of public assistance recipients is, in many ways, the product of national and state level policy, the discourse of blame and responsibility is reproduced on a local level (Morgen 2001, Kingfisher 1998, Roberts 2008).

Inequalities in the U.S. health care system are another way to explore how social inequality becomes institutionalized. The United States’ profit driven health care system privileges private insurance companies who control access to health care resources (Becker 2007). This bureaucratic structure also influences the quality of care an individual receives. Steady employment no longer comes with the guarantee of potentially lucrative benefits packages which include the promise of health insurance, as domestic labor markets are increasingly relying on low-wage labors to fill temporary, seasonal, and part-time positions (Piven 2001). Both the U.S. labor market and the health care system are gendered and racialized as women and people of color disproportionately occupy low-wage labor positions as well as experience barriers in their access to health services (Mullings and Schultz 2006, Duffy 2005). Persistent poverty compounds these issues, and individuals living both below and above the poverty line are often unable to access the care they need or desire due to the prohibitive cost of treatments and pharmaceuticals.
Anthropology of Poverty

Judith Goode and Jeff Maskovsky (2001) argue that economic polarization, political demobilization, and market triumphalism are at the heart of new forms of poverty in the United States. In these models, the roots of poverty lie not only in an increasing economic gap between the poor and the prosperous, but in social and political decisions which facilitate cycles of persistent poverty. Although these policies and decisions are frequently made at the national level, inequalities are reproduced locally. Local power is not just exercised “upon participants within the decision-making process but also towards the exclusion of certain participants and issues all together” (Gaventa 1982). Incarceration, lack of health insurance, and inability to maintain employment with a living-wage are all examples of how national policy has affected the well-being of individuals on a local level (di Leonardo 2008). In these arrangements power is not necessarily overt, but is exerted through a series of actions and discourses which blame the individual for their inability to change their present circumstances.

Market triumphalism works under the pretense that all individuals have the same opportunities and access to resources. Built on the tenets of classic economic liberalism, market triumphalism supports deregulation and privatization which, in theory, remove barriers put in place by the state. Once those barriers are removed, all individuals, including the poor, should be empowered to make their own opportunities. However since market triumphalism places its value in individual choice, those who are unable to take advantage of the “benefits” accompanying deregulation and privatization are held personally accountable (Goode and Maskovsky 2001:9). Personal responsibility also becomes an important discourse
tied the market triumphalism. Since market triumphalism assumes all individuals have equal chance at “success,” those who “fail” are blamed for their inability to become economically stable or prosperous. Market triumphalism and culture of poverty work in tandem to create a social and political climate where persistent poverty is attributed to an individual’s personal shortcomings as opposed to the result of policies which shape social, political, and economic relationships at the local and national level.

Economic polarization is more than a socio-economic divide between the wealthy and the poor. Social and political relationships have been transformed as a consequence of economic restructuring. Unskilled part-time and seasonal labor positions in the service industry are quickly replacing once stable industrial jobs. Deindustrialization has had a dramatic impact on the nation as a whole, and rural communities have been particularly hard hit since workers in these communities have few living-wage employment options after deindustrialization has occurred (Lobao et al 2003). Deregulated markets also create an opportunity for predatory lending which has a direct impact on those living on the margins. Economic polarization cultivates an environment where personal debt which results from predatory lending practices are then once again attributed to the individual’s inability to manage their own finances, as opposed to a social manifestation of economic inequality which originates from a myriad of sources (Williams 2008).

Nowhere is this shift more obvious than through the social attitudes directed at women seeking public assistance. Piven and Cloward (1993 [1971]) argue that public assistance programs were designed to control poor and marginalized populations from
questioning institutional authority or taking action against state-based institutions which perpetuate inequality. The cycles of blame and discourse on personal responsibility which accompany a culture of poverty model, facilitate economic polarization and result in political demobilization.

The process of enrolling in WIC or participating in workfare can be demoralizing for women forced to endure lengthy counseling procedures before receiving their aid. Participants, who oftentimes already face multiple time constraints, are placed in the frustrating position of navigating multiple forms of bureaucracy in order to gain access to their aid while being forced to confront the racial and gendered stereotypes which frequently accompany that aid (Mullings and Wali 2000, Kingfisher 2001).

Along with the racial and gendered tensions associated with social services, welfare “reform” places physical limitations on national aid programs (Collins 2008, Mittelstadt 2005). The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) passed in 1996, now limits the amount of time individuals or families are allowed to receive aid from the state and strict guidelines control job placement and occupational opportunities.

In her book Disrupted Lives (1999), Gay Becker argues life in the United States is understood as a progressive continuum punctuated with misfortunes or “disruptions.” Although most of these “disruptions” are believed to be temporary, major changes can permanently alter the lives of individuals and households. Significant “disruptions” such as the loss of a stable job, divorce, or the death of a close family member can quickly and dramatically change social and economic stability.

Similarly, Brett Williams (2001) argues that death or prolonged illness can devastate
family networks or lead to insurmountable debt. Kin networks rely on one another for more than emotional support and care and extended families frequently rely on one another in times of financial crisis. When crucial members are removed from that network, entire families may fall into poverty.

By framing social inequality as personal responsibility, patterns of marginalization reified through policy and law are widely ignored. Market triumphalism and economic polarization work together to facilitate a social and political climate where the qualities associated with individualism and responsibility are not only valued in others, but internalized as well. This results in political demobilization, as residents feel they have no course of action. Economic polarization restricts health care options for the uninsured and those who do not have the means to pay for the cost of service, while political demobilization also serves to perpetuate health inequalities by limiting options and creating bureaucratic barriers for both clients and professionals. Market triumphalism, economic polarization, and political demobilization are exemplified by health inequalities. Like other national institutions, the U.S. health care industry is a private, profit driven system. U.S. health care functions under the premise of market triumphalism since it is theoretically a consumer-driven competition-based enterprise. Economic polarization creates a chasm between those who have access to health insurance and health care resource and those who do not. Political demobilization perpetuates a cycle of blame linked to the discourse of personal responsibility. Although these concepts are theoretically based, they result in material consequences.
Health Inequalities and Intersectionality

At any given time roughly one sixth of the U.S. population goes without health insurance (Becker 2007). The presence or absence of health insurance contributes significantly to opportunities or constraints that face an individual or household attempting to navigate the U.S. health care system. Private insurance companies control access to facilities, physicians, pharmaceuticals, and therapies (Grembowski et al. 2002). Economic polarization creates a paradox for the uninsured, since uninsured parties are expected to pay for health care out of pocket; however these same individuals frequently occupy low-wage labor positions which impede their access to health insurance. Although the uninsured frequently circumvent the private system by using emergency facilities or local clinics; these options are frequently overcrowded, expensive, and oftentimes lack resources. This influx of uninsured, underserviced clients leads additional administrative duties for health care professionals and who are limited in the types of care they are allowed to administer (Boehm 2005).

However health care options for the uninsured are tenuous at best. Health care professionals are not only limited in the types of care they are able to offer to the uninsured, but are limited in the interactions they have with those potential clients. Individuals who are uninsured not only face barriers when attempting to find and access facilities, but are frequently unable to schedule appointments due to the high client volume these facilities are expected to treat (Blanchard et al. 2008). These problems are not alleviated for individuals who qualify for Medicare, Medicaid, or other state based low-income insurance programs. Since primary care providers are given the option as to whether or not they chose to accept clients who are associated
with these programs, participants in state-based health care programs are potentially as limited in their choices as the uninsured (Hall et al. 2008). For communities where health care facilities are insufficient, the choices available to the uninsured become even more uncertain if practitioners refuse care on the basis of insurance status. This is frequently the case for uninsured individuals living in rural communities. These individuals face a dual form of marginalization, because not only are facilities and practitioners scarce in these communities, but opportunities to secure jobs which would provide an individual and their household with health insurance benefits are also limited (Burman et al. 2006).

Health policy is created at the state or national level, while health inequalities are reproduced at the local level. Jill Quadagno (2004) argues that physician specialization, as much as health insurance companies, perpetuate the privatized health care in the United States. However, health care professionals often face many of the same frustrations as their clients. Health care professionals are frequently expected to mediate the tensions between ill clients and administrators who restrict access to resources. The interactions between clients and professionals often reproduce health inequalities through a cycle of blame. The client blames the professional for their lack of compassion and professionals blame clients for their inability to monitor their health. These moments of tension that Stacey and associates (2009) label “demanding encounters” punctuate the creation of health inequalities. Although the power relationship between health care professionals and clients frequently favors the knowledge and authority of the professional, that does not mean the professional does not care for the well-being of their client. By framing these
interactions as “demanding encounters,” the focus is directed towards the language, posturing, and physical environment in which the encounter takes place, as opposed to placing blame for the tension on the behavior or belief system of either party (Stacey et al 2009).

As a product of larger forms of social inequalities, health inequalities are informed by a number of perspectives and experiences. Patricia Hill Collins (2000) argues that deconstructing social relations using an intersectional approach is particularly useful when examining inequality in the United States, since socially constructed paradigms such as race or gender often work in tandem to not only create inequality but mask larger institutional barriers. Intersectionality allows for a better understanding of how those experiences become material constraints (Mullings and Shultz 2006). But while an intersectional approach to understanding health disparities can serve as a critique of the biomedical paradigm, intersectionality is not only useful in a theoretical context (Weber 2006). An intersectional approach provides a space in which to create a useful dialog on health inequalities, as well as propose solutions to real world problems. In this sense an intersectional approach challenges the racism, sexism and class stratification which frequently manifests in a biomedical model of care, as well as creates a space for political mobilization in response to health inequalities (Morgen 2006).

In the beginning of the twenty-first century, Appalachia, like the rest of the nation is a space in transition. Deindustrialization and the outsourcing of labor have led to a decrease in living-wage jobs, although a focus on personal achievement through professional channels still exists. In this time of economic uncertainty, Kentucky is
once again becoming a symbol for inequalities in education, health, and poverty. The scope of industries considered representational of the state, most notably mining, are also changing. As these employers who have traditionally supplied living-wage jobs are becoming increasingly mechanized, the need for human labor is reduced. Growth in the service industry, as well as the reality that many working in service and food do so at or below minimum wage, also creates a need to articulate a distinction between working class and working poor. With many local governments now claiming states of economic emergency, it is feared state and federal level social service programs will suffer the most.

**Methods**

This study was conducted over a nine week period in the summer of 2008, in the central/eastern Kentucky counties of Madison, Jackson, and Rockcastle. My primary residence for the duration of the project was in Madison County, where I felt I had the best opportunity to meet possible study participants and take part in community activities. I also chose Madison County as my primary field site because I felt its location between urban Fayette County and more rural Rockcastle and Jackson Counties could possibly help define the issues rural residents encountered as they attempted to access health care resources both in their own communities and nearby towns and cities. In the spring of 2008, I commuted twice a week from my home in Lexington to Madison and Rockcastle counties in order to collect preliminary data on populations of interest in each county. I also used this time to familiarize myself with Highway 25 and learned to navigate the back roads in each county. I was informed by my initial contacts that Highway 25 provided access to roads and communities Interstate 75 did not. Although I did not collect detailed field notes at this stage, I did
use this time to map out potential logistical issues in each community as well as identify potential lines of inquiry. Upon relocating to my primary field site in July of 2008, I began collecting daily field notes which were later used to frame events and contextualize interactions with research participants (Emerson et al. 1995). Participant observation was a key component in the early stages of my field work, allowing me to better understand community dynamics as well as construct appropriate lines of questioning (Bernard 2006: 360-361).

My initial contact in Madison County was Beth\(^1\), a nurse, personal friend and former colleague of one of my Lexington acquaintances. Even though my original project was designed around the narratives of female health care workers, I found recruiting interested participants and scheduling interviews with health care professionals to be challenging. While Beth put me in contact with six nurses and nurse practitioners she was acquainted with in Madison and Jackson counties, three had moved out of the state, two declined to be interviewed, and one was willing only to contribute demographic information. Despite these set-backs, one of the nurses who declined introduced me to Irene, a retired nurse whose contribution throughout the duration of the project was influential in shaping how I constructed my lines of inquiry. Since I was interested in not only issues of health, but in the way social and economic policies shaped women’s lives, I expanded my study population to include the experiences of women who used forms of public assistance.

There were four women whose participation was instrumental in the recruiting process. These women also gave me essential feedback which helped me shape and

\(^1\) All names have been replaced with pseudonyms.
refine my lines of questioning. Each gave me invaluable information about themselves and their communities. Including Beth and Irene, these women were: Norma, a sixty-five year old Madison county business owner and Amy, a thirty-one year old retail associate and Lee County resident. I had weekly contact with both Norma and Irene and they provided me not only with insightful narrative, but a unique form of maternalistic constructive criticism. They teased me about my wardrobe and personal life, my institutional affiliation, and my home state. However they also gave me honest feedback on my research questions and provided guidance on appropriate ways to frame my questions in order to make women in their communities feel comfortable.

There were a total of twenty-nine participants in the study: twelve key informants and sixteen secondary interviews. All participants were female, and ranged in age from 22 to 66. Each of the key informants participated in at least one interview session, which lasted between one hour and three hours. Ongoing conversations with Norma and Irene were recorded as follow-up interviews, and Amy contacted me several days after our initial meeting to provide additional information on several topics we had discussed during her interview. In two instances informal conversations with key informants developed into recorded follow-up interviews. One participant, Camille, asked to complete her interview over a number of days due to conflicts in her work schedule. Secondary interviews contributed demographic information and these women were willing to answer basic questions which related to

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2 Work schedules were a simple and common complication I did not take into account when initially designing my research questions or interview schedule. After meeting Camille I offered future participants the option to participate in several short interviews that worked with their work schedules and break times.
several overarching themes in the project; however they did not participate in extended interviews. In all but five cases, participants in secondary interviews were women I met in local businesses, at community events, or in public spaces. These participants were not introduced to me by one of the study’s primary participants.3

The only criterion used to select participants was gender, since I was specifically interested in exploring how gender might influence the types and availability of care women were able access. All participants listed their race as “white”; however a wide variety of household, educational, and personal backgrounds were represented in the sample population. There were also no limits placed on age, occupation, or income. Other exclusions included minors and women who had not sought professional care, particularly within a biomedical system, in the previous year. Although I met one of my key informants and eleven of my secondary interviews through casual conversations I had with women in each community, snowball sampling became my foundation for recruiting and selecting study participants (Bernard 2006: 192-193). I met seven of my key informants and the remaining members of my secondary interview population through conversations initiated by Norma, Irene, Beth, or Amy, or through contact information provided by one of these four women. I found that snowball sampling introduced me to potential study participants I would not have otherwise been acquainted with. This process also secured a level of trust that I did not encounter with the women I approached through the random sample. Although questions of representation can arise from sample populations built on relationships

3 The exceptions are STR-001, STR-002, and MIS-002 who are members of Norma’s social network. The demographic data supplied by these three women was tied to an informal conversation which took place in Norma’s store. LIB-001 and LIB-003 were library staff who I interacted with regularly but were not interested in longer interviews.
formed with a select few, this form of sampling also provides the researcher with a legitimacy in the community and frequently encourages unguarded answers to questions from future participants (Le Compte and Schensul 1999). Ultimately the diversity of lifestyles and experiences present in my sample population provided me a wide variety of narratives to choose from.

My interaction with all participants began with a standard set of questions consisting of basic demographic information which allowed me to situate participants within particular geographic, personal, and professional environments. I chose to ask and record the answers by hand as opposed to tape recording them or presenting them to participants in the form of a survey. In instances where study participants were already well acquainted with me or the project, I entered answers directly into a pre-designed computer spread sheet. I hoped this format would present a more casual environment, and in several cases the survey questions did result in longer conversations. This process also allowed me to establish a standardized format with which to approach the interview process since I was apprehensive about conducting interviews. In the early stages of my field work these informal surveys also served as a guide, which later helped me construct larger research themes. Although the demographic questions were organized in this way, they also changed as my field work progressed. Questions related to personal or household income were eventually dropped from the data set, due to the fact that many participants were not comfortable sharing this information. 

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4 See Appendix 1, Basic Demographics
The second set of questions was broken down into three sections. The first section “Means of Care,” included questions regarding health insurance, federal or state based public assistance, and criteria informants used when choosing health care facilities for their households. The second section, “Preventative Care,” centered on questions connected to recommended annual examinations for women, including pap smears and mammograms. Also included in this section was a miscellaneous column which cataloged individual participant’s specific health needs, including diabetes screenings and pre-natal care. The final section, “Self-Care/Decision Making,” included questions regarding over the counter and holistic modes of self-treatment as well as questions pertaining to networks of care and health care decision making. I used these three sets of questions as a tool to explain the larger objectives of the research project to potential participants. After completing this portion of the interview process I invited the women to participate in formal recorded interviews.

Lines of questioning for the formal interviews were divided into two categories: access to health care and health care decision making. Eleven of the twelve key informants framed their responses in relation to their experiences within biomedical systems. The only exception was Amy, who framed her answers to questions regarding access to care and treatment options for her household through the language of “alternative” and “holistic” care. Although she argued that these options were “better to heal the whole person,” her opinions were shaped by her distrust of biomedicine. Since eighteen of the study participants were without health insurance at the time of their interviews, questions pertaining to perceived quality of care were

\footnote{See Appendix 2, Health Demographics}
also included. Using an intersectional approach, I was interested in how class and
gender intersected with region, or more specifically county, in order to provide
opportunity or constraint for those navigating the U.S. health care system (Weber
2006). Specific lines of questioning for women who were not health care
professionals included obstacles women encountered with health care facilities and
attitudes towards health care workers. I asked Beth and Irene questions pertaining to
the quality of care their practices offered and constraints they felt their clients
encountered. Their narratives provided an alternative perspective further illustrating
the complex set of regulations clients faced in the U.S. health care system. Based on
the premise that health inequalities are the result of social factors other than health
insurance or adequate medical facilities (Mullings and Wali 2000), respondents were
also asked questions pertaining to lifestyle changes, exposure to emotional and
workplace stress, and social stigma which would contribute not only to health care
access but quality of life.

Several similar themes began to emerge as both community members and health
care professionals shared their experiences. Nurses Beth and Irene were both
frustrated by the influence health insurance companies had on the type care they were
allowed to administer or the restrictions placed on potential clients who were
uninsured. There was also a shared level of concern over the immediacy of care and
health outcomes for the uninsured. Both health care professionals and potential
clients felt that emergency rooms and clinics were not ideal spaces to seek primary
care; however each viewed the facilities’ responsibility towards client care
differently. The professionals were sympathetic to colleagues who worked in these
high stress environments, while uninsured community members were angered by the bureaucracy and unfair treatment they felt resulted from unsympathetic physicians and nurses. Blame became a central theme for both parties as clients blamed professionals for providing inadequate care heavy with judgment; while professionals blamed clients who they felt refused to take responsibility for their health.

**Research Problems and Dilemmas**

Positionality is always a source of worry and tension during the ethnographic process (Jackson 1990). I feared that my presence not only as a researcher, but as a single childless woman, entering communities where this positionality was sometimes met with suspicion would affect my interactions with potential participants. I soon realized it was my positionality as a student which was problematic in the early stages of my research. During our third meeting Norma informed me that in order to gain respect in her community I needed to “wear my hair like a normal person” and “stop dressing like a dirty hippie.” She felt I looked like a “crazy liberal college student” as opposed to an adult conducting a research project. While my style of dress and my status as a student was disconcerting for some, many people in all three counties I frequented were accustomed to student run research projects facilitated by nearby Eastern Kentucky University (EKU) and Berea College. In these cases I found carrying my student ID was an easy and effective way to legitimate my presence. Despite some negative feedback from residents who felt student run research projects were generally poorly executed or lacked concern for the community, most people I

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6 See Anglin (2002) and Scott (1995) for further discussion.

7 Although “student” appeared to be the way I became identifiable to most of my informants, it is entirely possible my single, childless status contributed to that label.
encountered were inquisitive, curious, and receptive. Many were interested in how my results could be applicable to them and questioned the relevance of anthropological research in general. Several of Norma’s friends commented that they felt research projects with only academic applications used their community as a population of convenience, and would not benefit them in a material way. I responded that academic research in general, and anthropological research in particular did have implications for social change; however several individuals I initially approached declined to participate based on previous experiences with university sponsored research projects. While these constant questions and critiques became frustrating, they also forced me to create short, concise responses when framing my project to potential participants. This exercise later turned out to be helpful as I began to organize my data.

Physical location also proved to be a challenge during data collection. While I spent my first three weeks in the field seeking out both informants and locations conducive to the interview process, I soon learned social life in the communities where I worked centered around the home instead of public spaces. Since my time in these communities was limited, I did not have the opportunity to foster connections which would allow access into these intimate spaces. Although I cannot say with any certainty that this dynamic would have changed if I had spent a longer period of time in each county, participating in active church and school communities could have allowed me additional access to potential informants. I eventually established myself in several well trafficked public spaces, including two public libraries, the outside break area and pharmacy in a large box retail outlet, and a locally owned business.
Once I made contact with possible participants, I offered to conduct interviews in public spaces where I believed the women would feel comfortable. While close to half the secondary interviews I conducted took place in coffee shops or restaurants, the public library became a popular and somewhat private space where daily children’s activities served as a form of childcare and allowed the women I interviewed a period of uninterrupted concentration.

I initially explored a wide variety of interview spaces, however the library, the store, and employee break areas produced the most fruitful results. These spaces provided informal environments which were relatively quiet and, in many cases, air conditioned. The pharmacy proved to be a problematic location, in part, because customers waiting for prescriptions oftentimes wandered the store instead of staying close to the counter. The area was also frequently monitored by a store security guard who made some potential participants feel uncomfortable. The retailer’s close proximity to an urgent care center may have also influenced the demographic frequenting the pharmacy. The clinic served uninsured patients, was located close to a major road intersecting two counties, and featured a sliding scale payment policy. However its location would have been dangerous to access by foot and public transportation did not appear to be common in the area. This may indicate the clinic’s clientele were individuals who had access to transportation or could afford the fee associated with the services provided by the clinic.

Norma owned and ran the store where I conducted several interviews, including two with her and one with Leslie, a store employee. Norma’s store was a hub for community gossip and provided an excellent location for collecting field notes. Even
though Norma wanted me to keep research questions to a minimum in the store’s main sales area, she did allow me to use the employee break room to conduct interviews and organize my notes. Norma’s participation in the study was instrumental in granting me access to residents I would not have encountered otherwise and her social position in the community legitimated my presence. However her confrontational communication style and her desire to participate in, and oversee interviews conducted in the store may have influenced some of the responses I received. She eagerly gave her opinion to other informant’s responses and interrupted or corrected others on several occasions. Due to these distractions, I chose to conduct interviews with individuals connected to Norma’s social network in locations other than the store.

The public library offered daily activities for children as well as free internet access, which in turn brought in a diverse population from across several counties. However like the pharmacy, the library patrons had a higher likelihood of reliable, personal transportation which may have skewed the population demographic. The library participants on average had a higher level of education, and the presence of two library employees with post-secondary educations, stable employment, and health insurance was not necessarily representative of the larger demographic I met in each of the three counties. However their presence in the study population does challenge stereotypes of Appalachian residents as isolated, poor, and uneducated.

I also encountered several issues of disclosure associated with collecting demographics on socio-economic status. While all study participants were comfortable detailing their level of education, current occupational status, and living
arrangements, most were uncomfortable discussing their current income. Even though study participants were assured the information they divulged would be kept confidential, most said they did not share this information with intimate friends or extended family. Reluctance to divulge personal income may have also been linked to issues of privacy since most of the interviews were conducted in public spaces. Although lack of current income complicates an argument about class, it does provide a space to problematize the way class is constructed. In the United States class occupies a social space not bounded by socio-economics but shaped in material ways by financial opportunity and/or constraint (Bradboy-Jackson and Williams 2006).

Even though this project began as an attempt to link the construction of Appalachia as social and physical space to a larger discourse on health inequalities, I ultimately found it difficult to draw direct parallels between these two themes through a specific line of questioning. Many of the women I interviewed acknowledged they felt they encountered discrimination in both medical and non-medical environments based on where they currently lived, where they had grown up, or the way they spoke. However they did not associate this discrimination with a specific regional identity. They framed the marginalization they experienced in terms of education, poverty, or stereotypes of rural communities held by urban peers and colleagues. I found the most productive lines of questioning to be associated with resource access and availability. The women were eager to talk about the problems they encountered with the U.S. health care system as well as frustrations with social services, and these narratives produced a discourse of social inequality which extended far beyond issues of health. I would argue that although Appalachia as a specific place or idea did not
directly enter into most of the discussions I had with participants, the narratives I collected on health inequalities speak to issues of regional inequality present in Appalachian communities in Kentucky.

The following chapters will explore the experiences women living and working in Madison, Rockcastle, and Jackson counties as they interact with both institutional bureaucracy and administrators connected to state based public assistance programs and the U.S. health care system. Although a concern over financial stability or instability was a common topic of conversation with all my key informants, the constraint experienced by my informants encompassed a myriad of social issues. Chapter 2 will deal with issues related to accessing public assistance in the post-welfare reform era, including workfare and the Women, Infants, and Children (WIC) program. This chapter will also focus on the stigma women feel as participants in these programs, as well as the cycles of blame which emerge in the interactions between clients and case workers. Chapter 3 will feature the concerns health care professionals have for their colleagues, their clients, and the uninsured. The presence or absence of health insurance plays a significant role not only the types of care an individual is able to access, but also in the care hospitals, clinics, and private practices are able to offer. In Chapter 4, I will begin to explore how the constraints my informants encountered are a reflection of domestic policies put into action at the end of the twentieth century. Although these interviews were conducted prior to the current debate on health care reform, the narratives my informants shared speak directly to the way privatization has created gaps in access and quality of care, thus allowing people throughout the country to fall through the cracks.
Women’s health and well-being can be influenced by a number of social factors including household dynamics, personal loss, employment stability, or socio-economics. Although multiple factors can influence the choices women make in regards to their health and well-being, these decisions are usually not made from a position of autonomy. Rather, health and lifestyle choices are a series of negotiations based on the expectations of larger social networks. Women are disproportionately affected by divorce and occupy positions as low-wage workers more often than men (Mullings 2001, Weigt 2006). These issues not only lead to problems pertaining to physical health, but influence emotional health as well. When asked what issues they felt would have the most devastating impact on their lives, study participants listed divorce, death or serious injury of a close family member as well as job loss as their top concerns.

Eleven of my study participants were currently receiving some form of public assistance, and seven additional participants revealed that their households had used public assistance at some point in time. Throughout the twentieth century, women, particularly women of color, have increasingly become the visible symbol of public assistance and by association a visible representation of poverty (DiFazio 2006, Collins 2008, Roberts 2008). In 1996 the Personal Responsibly and Work Opportunity Act (PRWORA), designed to “reform welfare” further intensified these social attitudes as the bill proposed “to restore the American family, reduce illegitimacy, control welfare spending and reduce welfare dependence” (United States
House of Representatives). Not only is the language used in PRWORA gendered as it seeks to “reduce illegitimacy,” but it also makes assumptions tied to race since the wording of the bill specifically singles out African American women as the demographic most likely to become dependent on state based social services such as welfare (Mittelstadt 2005). The document further asserts “the absence of a father in the life of a child has a negative effect on school performance and peer adjustment” (Article N), and “the greater the incidence of single parent families in a neighborhood, the higher the incidence of violent crime and burglary” (Article P).

The workfare program which resulted from PRWORA was designed to support women’s reentry into the workforce by limiting the time recipients were eligible for aid. As a result, workfare also cut off social services for women who needed those resources the most. The discourse of PRWORA not only reinforces culture of poverty - which locates poverty in particular behaviors or culture practices - but it ignores the way gender, race, and class articulate with one another creating multiple barriers for women and people of color (Morgen and Maskovsky 2003).

Low-Wage Labor and Workfare: Camille’s Story

Lifestyle changes can have a dramatic impact on women’s financial and emotional security (DiFazio 2006). Camille was in the process of restructuring her life after a lengthy and hurtful divorce. Now a single mother with three small children, Camille felt she had little time to relax and worried she would not be able to provide opportunities for her children. Camille’s anxiety manifested itself in her body as she fidgeted with her hair and clothes and was easily distracted by passersby. She also chain smoked throughout the duration of our three meetings. She said she rarely got
more than five hours of sleep a night and was worried that her heavy smoking and her “caffeine addiction” might be contributing to the problem. Although she described her current mental status as “tired,” Camille said she considered herself lucky since she was able to find steady employment, albeit low-wage employment, easily. She said she was also fortunate to have an extensive family network that had been able to provide emotional support, housing and childcare during her divorce. She was struggling to support her family with a paycheck that fluctuated bi-weekly and was battling the debt which had grown exponentially in the wake of her divorce. Camille felt that fights over financial instability and debt had been major factors in her divorce. Even though Camille was trying to avoid using credit cards, her ex-husband was habitually delinquent with child support payments. She found her part-time job as a hair stylist, a job that relied heavily on tips, frequently did not produce enough income to cover her monthly expenses, thus forcing her to rely on credit cards to purchase gas for her car and groceries for her family.

Camille had dropped out of high school at sixteen when she discovered she was pregnant with her oldest daughter. With the encouragement of her family she was able to complete her GED before the birth of her second child. Although she was not employed for the duration of her marriage, divorce forced her to reenter the formal labor market. Camille felt that having her GED “because [she] wanted it, not because the workfare people told [her] to,” gave her an advantage when applying for jobs. Initially she had taken a second shift job at a gas station. However Camille eventually decided to become a hair stylist. She was able to fund her education through a combination of grants provided through the workfare program and loans
provided through the cosmetology school. Although she was happy with her career choice, she felt financing her education had been frustrating and confusing.

Getting money from [the school] was no big deal; most of the girls I was takin’ classes with were getting money from the school so we could all bitch about it together. They send you these notices all the time, even when you’re still in school tellin’ you how much money you’re gonna owe them someday…Ya know like when you’re having a bad day and you get a letter in the mail that says stuff like “you owe us this much money.” We could all laugh about it and say when you get us a job then we’ll give you your money (Camille, Interview 2).

At the time of our first meeting Camille was working part-time as a hair stylist for a salon attached to a large box retailer who regularly employed workfare participants. Although she was currently without health insurance, the parent company that owned a controlling interest in the salon did offer benefits packages for employees who had achieved full-time status. These benefits packages included not only health insurance, but also the chance to accrue personal days and vacation time, as well as the opportunity to invest in 401k, life insurance, and company stock options. Supervisors often promoted these benefits packages in employee meetings as a way to encourage productivity and efficiency within the workforce. Even though these meetings frequently featured a testimonial from an employee who had successfully achieved the desired benefits, Camille described the interactions as “dangling a carrot in front of us,” since most of these testimonials were companywide and did not reflect the working environment in her particular store or district.

Camille said she and other associates were frustrated because they felt the benefits packages were intentionally placed out of reach for most of the company’s hourly and part-time employees. Camille said her inability to achieve full-time status was not
based on a lack of initiative or dedication to her job, but to scheduling issues associated with the large number of workers who were also employed as stylists. In order for Camille to achieve full-time status she would have to accumulate “enough” hours annually in order for the company to recognize her as full-time and enroll her in the benefits program. She was unsure how many hours constituted “enough.” Based on conversations she had engaged in during her breaks she surmised she would have to average between 35 and 40 hours a week. She was currently averaging between 25 and 30 hours a week.

While attending cosmetology school, Camille had also participated in the workfare program. Although Camille said the small amount of money she had received from workfare to help finance her education had helped her pay for books and supplies, she felt the program had not ultimately helped her build the skills she felt she needed to keep a job. Camille said she found the cosmetology school she attended through an online directory because she did not want to attend the school recommended by the workfare program. She claimed her friends who had attended the school associated with workfare had negative experiences with the instructors and had not been able to make contacts that allowed them to gain employment after they graduated. She had also attended a seminar sponsored by workfare designed to help participants create a résumé and navigate the interview process. Camille described the seminar as a “waste of time” and said that the information she was given did not make the interview process any less stressful or frustrating. In her study of job opportunities for workfare participants, Jane Collins (2008) points out that employers often use the workfare program as an excuse to deny recipients opportunities at full-time living
wage jobs, thus forcing employees to maintain their positions as low-wage part-time workers. This denial comes not only in the form of education or job placement, but also in the surveillance tactics used to monitor employed participants or threats to withhold services from those who deviate from the program’s guidelines (Collins 2008). Camille felt that workfare caseworkers were insensitive to the needs of their clients and the obstacles they faced in their everyday lives.

I hated dealing with the workfare people...they were nice, like fake nice, to your face, but really rude on the phone. They’d check in on you to make sure you were doin’ what you said you were...like they’d call the school to make sure you were there and stuff...I know this one girl who had to take a couple weeks off ‘cause her daddy was real sick and she had to go home to help her momma and the workfare people threatened to cut her off completely. And she really needed workfare...So we were all kind of nervous for a while and I made sure to keep my appointments with my caseworker and stuff like that so they wouldn’t think I wasn’t really in school or that I wasn’t really trying to take care of my kids (Interview 2).

Camille and her colleagues were frustrated and angered over the control they felt workfare exerted over their lives. Camille felt many of the questions she was expected to answer when she met with her caseworker were “inappropriate” since they pertained to her personal life and the lives of her children as opposed to her progress in her career. In follow-up interviews with her caseworker, Camille was frequently asked questions regarding her current romantic relationships, childcare arrangements, and familial expectations. These lines of questioning were not only highly gendered, but served as a form of surveillance and scrutiny regarding Camille’s personal life. When I asked Camille how our interactions were different than her meetings with her caseworker, since I was essentially asking her questions on the same topics, she responded:
I don’t have to talk to you if’n I don’t want to, and you come to me I don’t have to leave work or figure out what I’m gonna do with my kids when we talk. And you don’t want nothing from me, if I don’t want to talk about something that’s fine…When I see my caseworker I feel like I have to answer all the questions she asks me or I’ll look like I’m trying to hide something (Interview 2).

Camille felt that if she did not adequately answer the questions the caseworker asked then she would be “punished” and her aid would be withheld. Although Camille had never been explicitly told she would be denied benefits if she refused to divulge personal information, she thought it was “risky” to refuse to answer some of the questions she was asked. Camille felt strongly that there should be some form of assistance available to “good people in need,” but she felt workfare was not a good option. She cited “judgmental caseworkers,” “time limits” and “bad job placement” as the reasons why many of her friends and colleagues were unable to disentangle themselves from the workfare program. Workfare as a program facilitates and perpetuates poverty, as opposed to creating sustainable solutions to the issues of living wage employment (Johnson Dias and Maynard-Moody 2007). The program also functions within the culture of poverty model as it blames individuals who are unable to escape a cycle of persistent poverty. Camille told stories about colleagues who had lost their jobs and were told they were unable to reapply for workfare or other forms of public assistance because they had exhausted their eligibility. She also became visibly angry when she talked about how women who were “just trying to take care of their kids” were treated poorly by public assistance programs while men like her ex-husband, who was frequently delinquent with his child support payments,
was not held accountable for the care of his children in the same way she was. Like Camille, her friends and colleagues who were caught in the workfare system had frequently been faced with life changing circumstances such as divorce or the death of partner of close family member. They had little or no opportunity to accrue savings, leaving them few options other than state based public assistance programs.

Stories from the WIC Office

Workfare was not the only form of public assistance which constrained study participants’ choices. For Ashley, a young woman with two small children who had been forced to move in with her mother after losing her job, the thought of accepting public assistance or joining the workfare program was embarrassing. Although she tried to support her family through a series of short-lived, part-time jobs, she soon found the process overwhelming. She agreed to sign up for the Women Infants and Children (WIC) program after her mother revealed she had used public assistance for a brief period of time during Ashley’s childhood. Prior to her own experiences with WIC, Ashley said she openly judged women who looked to public assistance for relief, describing them as “lazy” or “bad mothers.” She was now concerned that some of that judgment and blame would be directed at her. Ashley’s narrative illustrates how she continued to struggle with feelings of guilt and blame.
I didn’t want anyone to know I was doin’ it ‘cause ya know it’s like welfare, and that stuff’s for poor people. And I’m tryin’ to get another job and I’m not lazy so I didn’t want people to think that I was just sittin’ around collectin’ food stamps… I found out some of my other friends were doin’ it and I don’t look at them like they’re poor so I went down to the office to sign up. No one there makes you feel comfortable, they make you feel like they think you’re stealin’ from them or you’re a bad person for asking for it or something. I still think it’s disrespectful [the way she’s treated] and I don’t understand why they have to be so hateful. I can’t wait ‘til I don’t have to do it anymore, but I guess I gotta deal with it for now (Ashley, interview 5).

Ashley’s story was not unusual, and frustrations concerning WIC and other administrative offices connected to low-income housing and public assistance were common themes in many interviews. Ashley said she felt trapped due to her current living arrangements as well as her inability to provide what she believed to be a comfortable and happy life for her children. She was initially hesitant to answer questions about her experiences with WIC because she was afraid “people would judge her.” She claimed she was reluctant to tell acquaintances she was living with her mother and would only visit her caseworker if a close friend or her mother accompanied her. Ashley also regularly sent her mother to do her grocery shopping since she knew many of the cashiers in her small town and did not want them to associate her with public assistance. Even though her WIC funds were distributed on a card that resembled and worked like a credit or debit card, she knew the cashier had to push what she called the “food stamp button” signaling to both the cashier and those in line that she was using government aid to pay for her purchases. The discrimination Ashley believed accompanied her participation in the WIC program is part of a larger discourse on personal responsibility. The personal responsibility
model, like culture of poverty, locates economic success and failure in the individual and blames participation in public assistance programs on behavior as opposed to institutional constraint (Mittelstadt 2005). Ashley was conflicted over how her own participation in the WIC program challenged her assumption that public assistance was “for poor people.” She did not consider herself poor, nor did she label friends and acquaintances who participated in the program “poor.” However she still described many of the people she encountered at the WIC office as “lazy” because she felt they had poor personal hygiene and complained about not being able to find work. Ashley felt that physical appearance was an important indicator of who was “poor” and who was not. She said she paid special attention to her clothing and accessories and tried to wear her hair in a “fashionable” style when she met with her caseworker so she would appear approachable and friendly. Ashley’s refusal to shop in stores where she might be identified as a WIC recipient and the discourse of “laziness” she engaged in were forms of stigma management which allowed her to distance herself from individuals and practices which might result in others labeling her as “poor” (Latimer 2006).

Although Ashley actively distanced herself from other WIC recipients, she felt the WIC caseworkers were “disrespectful” of all program participants. She felt the WIC caseworkers and administrators judged her if her clothing was not neat or she spoke in slang. She also felt she was judged for being a single mother. Ashley had recently received her GED as part of a workfare training program. She did not feel the GED nor did the training she received provide her with skills which would aid her in finding permanent employment. Catherine Kingfisher (1998) explains that tensions
regarding social attitudes towards public assistance are shaped by relationships formed between caseworkers and clients. Caseworkers with limited power and political mobility within a larger bureaucratic structure are instrumental in giving and withholding information to clients they feel are more or less deserving of the services. Since clients are rarely exposed to administrators other than their assigned caseworker, the transfer or withholding of information is tied to the interactions between these two individuals as well as personal feelings of worth or blame. Even though Ashley felt her caseworker “ignored the bigger problems in [her] life, like finding and keeping a good job,” she never argued with her caseworker nor did she communicate her concerns to WIC supervisors.

Leslie, a twenty-five year old mother of two had also been forced to move back home with her mother after ending what she described as an “abusive relationship” with her children’s father. Like Ashley, Leslie made a clear distinction between herself and the individuals who she believed “abused” public assistance programs. She viewed her time as a WIC recipient as “a way to get back on [her] feet” and felt her high school diploma would give her an advantage over other job candidates who had received a GED. Leslie was currently working part-time in Norma’s store, a job she had been able to secure through her mother’s friendship with Norma. Since Norma’s store was located a county away from Leslie’s current residence, her round-trip commute was close to an hour on back roads if traffic was light and the weather was not bad. Leslie was meticulous in her appearance and regularly shared how she kept her skin so clear or how she managed to achieve the “right blonde” for her hair. Leslie also felt it was important to present a “clean” and “happy” image when she met
with WIC personnel. Although she felt her focus on her personal appearance was part of the reason she got along so well with her current caseworker, her experiences had not always been so positive.

Before I moved home I used to be on WIC for a little while when I was still livin’ in Lexington. They was really rude there…but then there’s a lot more poor people in the city than out here in the county…and you know lots of those people are just usin’ the system so they don’t have to work…Anyway this one time I went to see [her caseworker] and she was in a real bad mood… I had just done my nails and instead of tellin' me that they looked pretty or something, she said something like “It must be nice to have so much free time to sit around do your nails and not have to deal with anything while they dry” (Leslie, Interview 3).

This narrative reveals several interesting insights into Leslie’s specific experience with her caseworker, as well as her perspectives on the motivations of others participating in public assistance programs. Leslie and Ashley strategically focused on their appearances so as not to be “hassled” by their caseworkers and WIC staff. Both young women felt their cloths, hair, make-up and manicured nails should garner respect and that individuals who did not focus on these attributes were simply “lazy.” Leslie was angry and offended when her caseworker indicated her attention to her appearance was a reflection of laziness as opposed to an attempt to make a positive lifestyle change. While Leslie had been unhappy with her initial experiences with WIC, she considered her current caseworker a “friend” and sympathized with her work load, claiming she had a “really hard job that no one appreciated.”

Unlike Ashley who described the other individuals she encountered in the WIC office as “dirty,” Leslie’s understanding of who was deserving and undeserving of public assistance was tied to race and an urban/rural divide. She argued “poor” people using public assistance in Lexington were oftentimes poor because they were
“lazy.” She believed there were numerous opportunities for employment in the city and that many of the people who relied on WIC in Lexington were intentionally “abusing” public assistance because they did not want to work. She believed a “lack of good paying jobs” was the reason many living in Jackson County, including herself, were dependant on WIC. For Leslie, WIC in the city was also a highly racialized experience as she described WIC recipients in Lexington as individuals “living in the projects” or “living downtown.” She had also been concerned that she might be placed with a non-white caseworker in the city, justifying this concern with the belief that non-white WIC employees “wouldn’t understand what [she] was going through.” When I asked Leslie to elaborate on why she believed WIC recipients in the city, who were overwhelmingly African American, had different motivations for seeking public assistance that the predominantly white clientele in the county, she became visibly uncomfortable. She insisted that she did not see race as a factor which determined who did and who did not deserve public assistance. However Leslie’s description of urban WIC recipients as individuals who “live in the projects” speaks to the way discussions of race and racism become masked behind discourses on socio-economics and neighborhoods (Mullings 2001, Sanjek 1998). The discourse on personal responsibility is also used to ignore issues of institutionalized racism in the United States. Leslie repeatedly claimed that “anyone can get a job if they really try hard enough,” however she was reluctant to acknowledge that her own involvement in the WIC program was the result of the limited number of opportunities she had for securing long-term employment in her own community.
Amy, who was struggling to support two young children on a part-time retail salary, also experienced conflict at the WIC offices. Like Camille, Amy’s divorce had forced her to find alternative living arrangements and take on the sole financial responsibility of raising her children. Although Amy and her children shared their residence with Amy’s new partner, her “on again off again boyfriend had on again off again luck finding a job.” Amy’s partner’s inability to secure steady, reliable employment placed Amy in the position of primary provider for a household of four. Frustrated and tired of trying unsuccessfully to make ends meet, Amy arranged to meet with her WIC caseworker to discuss her possible options.

So I went to meet [WIC caseworker] and I didn’t take the kids with me because I wanted to really be able to pay attention to what she was telling me to do… I wanted to talk to her like two adults…But that isn’t at all what happened. The first thing she asked me was “where are your kids?” I told her I wanted this to be a conversation just between the two of us, and she got really uncomfortable. She kept asking me questions about how the kids were doing in school and who was taking care of the kids, stuff like that. She kind of told me without really telling me, ya know, that I was supposed to bring the kids with me because that was part of the way things worked around there. It was almost like I had no business being there unless I had at least one kid strapped to my leg or something (Amy, Interview 10).

Amy said that she had been enrolled with the WIC program for close to a year and had been placed with three different caseworkers in that time period. She said she had been accused of being “confrontational” by one of the office administrators and believed she was being reassigned because caseworkers refused to work with her. Amy challenged the power dynamics in her local WIC office by asking to speak to supervisors and threatening to contact state level administrators. She described this as the “retail approach to getting what you want,” since she often witnessed frustrated
customers employ the same tactics at her job. She was frustrated and angry that her manager almost always gave the customer what they wanted after they threatened to contact the corporate office, while the WIC administrators continued to ignore her and transfer her to unsuspecting new caseworkers.

Through their interactions with the WIC program Ashley, Leslie and Amy had internalized the discourses connected to individualism and personal responsibility although they performed those discourses in different ways. Ashley viewed her participation in the WIC program as a reflection of her inability to successfully perform a social role as a responsible worker and mother. She was “afraid” to visit her caseworker because she did not want to be judged. She was quiet and submissive during her interactions with WIC employees because she feared she might be denied desirable benefits. Leslie was also afraid to be judged, however she actively created obstacles between herself and her caseworker. She frequently missed appointments or came late to appointments she felt were “inconvenient” to her schedule. She had also programmed her phone with a specific ring tone that would alert her incoming phone calls from her caseworker. She laughed when she told me she “almost never” picked up the phone when she knew someone from WIC was calling. Amy described the public assistance she was receiving as a “right” she deserved because she was a “hard working woman who had fallen on hard times.” She openly challenged the WIC program guidelines and questioned the authority of caseworkers. Each woman viewed their participation in the WIC program as temporary, and each woman said they believed WIC caseworkers unfairly judged women who turned to public assistance to take care of their families. However their individual interactions in their
local WIC offices were likely influenced by more than a shared gender. Age, community and household dynamics, education and living arrangements very likely allowed Amy to feel she had power in a situation where Ashley and Leslie did not.

Public assistance programs like welfare or workfare, in theory, are designed to service a diverse demographic. However discrimination based on gender or race have created a climate where these institutions not only create constraint, but reinforce social attitudes which judge who is worthy to receive aid and who is not. The marginalization the women I interviewed experienced was far more complicated than simply examining issues tied to entitlement. Although these women experienced constraint as they were forced to navigate the bureaucracy that controlled their access to aid, individual relationships and interactions, between caseworkers and clients, clients and employers, and clients and clients shaped how the women understood the worth of that aid. The following chapter will explore how these individual interactions, and the discourses of responsibility and blame which accompany them, are acted out in medical practices, hospitals emergency rooms, and clinics. For those attempting to navigate the U.S. health care system and those who have chosen careers intended to bring comfort and care to the ill and distressed, private health insurance companies often interfere with the types and quality of care health care professionals are able to administer and clients are allowed to receive. Like the experiences of those unable to free themselves from dependence on public assistance, those struggling to receive or give care in the U.S. health care system are frequently constrained by bureaucratic structures.
Chapter Three

Health Insurance, Private Practice, and Professional Concerns

Health inequalities are constructed and maintained from numerous angles. The existence of health care facilities does not guarantee care for all members of the community, however the language of health is given a universal quality. The belief that all human beings have the right to good health has been incorporated into discourse and policy pertaining to human rights (Farmer 2005, Paluzzi 2004). This “right” to health includes not only access to physicians, medication, and health care facilities, but the right to live in a world free from interpersonal violence, environmental hazards, and substandard living conditions. Despite these guidelines, serious inconsistencies in access and quality of care continue to exist globally. In the United States, the privatized national health care system creates multiple levels of constraint, particularly for the uninsured.

The United States is currently the only western industrialized nation that does not provide health care for its residents, relying exclusively on a private profit-driven system (Becker 2007, Quadango 2004). Private insurance companies hold a great amount of power over the US health care system, and their presence greatly influences access to health care facilities and quality of care. Loss of living-wage jobs as a result of outsourcing and deindustrialization has resulted in economic polarization which affects all people. People of color, particularly women, disproportionately occupy positions in the labor force which are economically precarious and socially marginalized (Goode and Maskovsky 2001, di Leonardo 2008). These jobs provide poor wages, little room for advancement, and no access to
benefits including health insurance. Although government subsidized programs like Medicare and Medicaid are designed to assist particular segments of the population, the presence or absence of health insurance dictates the health care options available to most residents.

Health care professionals are not immune to these issues. The intimate contact nurses and nurse practitioners have with their clients gives them a unique perspective on the constraints present in the national health care system. During the course of my fieldwork I was fortunate enough to have a series of conversations with two nurses, Beth and Irene. Beth was originally from Harlan County, but eventually settled in Madison County after she finished school and got married. Irene was born and raised in Letcher County and had worked for several private practices and hospitals throughout Kentucky and Ohio over her thirty year career. Both women said they grew up in “poor” but not “impoverished” households and decided to pursue careers in nursing in order to provide care to Kentucky communities similar to the ones they once called home. They felt these communities were underserviced and physicians and nurses trained outside the area lacked sympathy for eastern Kentucky residents. However while both women had entered their careers hoping to service rural areas, each eventually found herself living and working in urban or suburban communities where resources and pay were better. Although the women held onto the belief that the primary job of a nurse was to provide compassionate care to those in need, the tensions they encountered with clients, administrators, and colleagues made them question the role care played in the current health care system.
Health Insurance and “Policing the Patient”

Beth and Irene worried that bureaucratic constraints kept many of the patients they saw from getting the care they needed. When asked what factors they felt limited community members’ access to health care, both women stated “issues with health insurance companies” as one of their primary concerns. Both women talked at length about the constraints they felt insurance companies placed on the types and quality of care their practices were able to offer. Irene cited pharmaceutical samples as a way private practices circumvented some of the limits insurance companies placed on prescriptions. She was frustrated that her former employer had refused to interact with pharmaceutical sales representatives, because she claimed she had worked for several practices which had stockpiled samples in order to offer them to clients who were being introduced to new drug regimens or clients who needed multiple prescriptions. She also felt the samples provided clients with a “trial period” to evaluate the effectiveness of the drug before they were forced to pay for a prescription which would be reported to an insurance company. Beth was also in favor of pharmaceutical samples, stating that upon request, she regularly gave women up to a six month supply of birth control pills for free.

As professionals, both women felt strongly that insurance companies had a significant influence on the way medicine was practiced. Having spent the early part of her career working in an emergency room, Irene was particularly sympathetic to colleagues who were forced to make critical decisions with little or no knowledge of the client’s medical history or insurance coverage. She explained she felt that there was no appropriate time during an emergency to find out whether or not a client had insurance.
Usually they [the physicians and nurses] don’t have time to ask the patient for proof of insurance…or if the patient is unconscious that leads to a whole different set of problems. Their job is to save lives and they’re going to do that regardless of whether or not the patient has insurance. Needless to say if someone is rushed to the emergency room they may have accumulated several thousand dollars in charges before they even see a doctor… (Irene, Interview 8).

Irene felt uneasy that emergency care could be restricted for those without insurance and was also concerned that insurance regulations interfered with the quality of care patients received in both emergency and non-emergency situations. Emergency rooms are increasingly used as primary care facilities by the uninsured (Begley et al 2006), and Irene was conflicted over this use of emergency services. She understood that the uninsured used emergency rooms as primary care facilities not because they were actively attempting to exploit the hospital resources or staff, but because their options for care were limited. Yet she also felt strongly that using an emergency room to treat minor ailments was an inappropriate use of the facilities. She described non-emergency traffic in the emergency room as a “symptom” of much larger problems:

I really do think this is kind of a new phenomenon…I really don’t remember seeing that many patients who weren’t seriously ill when I worked for [the hospital]. Since I mostly worked with children, I saw a lot of broken bones, and high fevers, and burns; occasionally a serious car wreck or some sort of life threatening illness…I know nurses who still work in that emergency room who seem to spend most of their shifts administering prenatal care and treating colds…Now it’s been almost twenty years since I worked there, so maybe it’s the paperwork and the way nurses are expected to interact with patients that’s changed, but I kind of doubt it (Interview 8).
Irene believed the high number of uninsured individuals who sought care in emergency rooms was creating additional stress for physicians and nurses, thus making them less efficient in emergency situations. She was concerned that patients who came to the emergency room with serious injuries or illnesses were forced to wait untreated, while the staff attended to minor injuries and colds. She also felt the amount of paperwork which accompanied every emergency room case, whether the patient was insured or not, was ineffective and created unnecessary work for the nursing staff that was usually in charge of keeping the paperwork in order. Irene explained that many of her friends who still worked in emergency settings also felt like their jobs were now about policing patients as much as they were about providing care.

I remember when I worked in [the emergency room] we had a standard protocol we used when talking to a patient for the first time…Basically we were supposed to find out what brought them to the emergency room, take their vitals, and get a brief medical history….Today it seems like there are so many check lists they have to use and so many questions they have to ask… One of my friends said it feels like being a police officer in an interrogation room. Not only do they have to deal with symptoms and medical history, they also have to ask patients questions about insurance. I know before I retired we used to have to fill out all these forms on pre-existing conditions and send them to the patient’s insurance company…Now nurses are even supposed to ask patients questions about who spends time in the room with them….Hospital administrators told the nurses too many visitors were distracting and there’s a good change they [the visitors] could bring illness into the hospital with them…so now one of the check lists has to do with who’s in the exam space with the patient. If that person isn’t a parent, spouse, or child then the nurse is supposed to tell them they can’t stay. It’s ridiculous! That information has no medical relevance and it’s wrong to make assumptions about the people someone relies on when they’re in pain (Interview 8).
Irene’s narrative says more about the way care is constructed in emergency rooms than it does about the paperwork used to document the emergency room experience. Although nurses assume a subordinate position of power to physicians in both emergency room and clinical settings, they occupy a position of power over the client as they are often in charge of scheduling treatments or therapies, mediating interactions between clients and physicians, and giving or withholding information to clients and their loved ones (Street 1992, Sinivaara et al. 2004, Riley and Manias 2009). Irene’s example also emphasizes a form of surveillance, as nurses literally patrol the physical space their clients occupy, searching for both foreign bodies and diseases. In this example, nurses become gatekeepers who are not only expected to monitor clients, but police their activities and interactions. Personal networks of care frequently extend far beyond immediate family, and these relationships not only influence the decision making process, but provide comfort in times of need and distress (Hansen 2005). Beth shared Irene’s outrage that a health care facility felt it was their “duty” to limit or restrict the amount of interaction a client had with the social network they relied on for comfort and support.

**Inside the Private Practice**

My ongoing conversation with Beth frequently included her concerns regarding the way paperwork and office policies took precedence over care in the private medical practice she worked for. At the time of our first conversation, Beth had been employed by a family practice for close to a decade. While she considered herself an optimistic person, she was increasingly disenfranchised with the demands of her job and dissatisfied with the position nurses occupied within the practice’s power
hierarchy. She felt that administrators and physicians held the most power, with nurses, who were oftentimes also called upon to organize office social events, staff the reception area and perform janitorial duties occupied positions with less power and authority. These positions were also highly gendered; four of the five physicians within the practice were male, as were the office’s chief billing and financial officer and accountant. All six nurses employed by the practice were female, and several part-time office positions in billing and reception were also occupied by women. The women working in Beth’s practice were cast in the role of caregiver both for their clients and the staff. Since many of the women also held part-time positions, their labor was not only feminized in its function, but their pay and semi-permanence illustrated gendered hierarchies within the professional setting (Jones 2001, Duffy 2005).

Beth explained she became a nurse because she had looked for meaning in her life and wanted to feel as if she was truly helping others. However she soon learned that working in a doctor’s office was not so different than the service industry jobs she held while she was in high school and nursing school. She felt the “red tape” associated with the administrative side of the practice interfered with her ability to deliver the care she felt patients needed and deserved. Beth said the nurses frequently complained about the paperwork that had to be filed on patients, either during or after every visit, because it added unnecessary stress to their days and hindered their ability to focus on the care giving process. Similar to the check lists Irene’s emergency room colleagues had to use when talking to patients, Beth had to submit paperwork to billing and accounts payable who had to contact insurance companies before
physicians or nurses were able to administer care. Beth frequently found herself in a tense position between a sick and frustrated patient who was left in the waiting room or examination room for a long period of time, and her superiors working in administration who felt it was not their responsibility to explain the limits of health insurance to her patients. Although her annoyance with practice administrators was evident, she complimented the physicians she worked with for respecting the nurses’ professional knowledge. She felt that most of the physicians in her practice willingly collaborated with nurses to come up with alternative treatments and therapies when insurance coverage failed.

The barriers Beth and her colleagues faced day to day are the result of both economic liberalism as well as social attitudes which marginalize and constrain individuals based on their class, race, or gender (Weber 2006). In the model Goode and Maskovsky label “market triumphalism,” deregulated markets built on private ownership fail or succeed based on the preference of individuals (Goode and Maskovsky 2001). In theory, profits generated by the U.S. health care system are the result of the choices made by individuals favoring one form of care or treatment over another. However the individual has little say in this course of action since access to treatments and therapies are ultimately decided by health insurance companies or government affiliated programs such as Medicare or Medicaid (Morgen and Weigt 2001). Beth’s analogy which linked her current profession to that of a low-wage service industry worker is poignant since market triumphalism models health care as a service based industry. The goal of the private practice is not only to make enough money to replenish medical supplies and provide wages for the practice’s
administrators, physicians, and nurses, but to turn a profit (Quadango 2004). Like other service industry employees, Beth frequently found herself caught between a paying client who viewed their access to care as a “right” and insurance companies and practice administration who limited the client’s access. In Beth’s mind the administrative, or “business” side of her job, contradicted her desire to be viewed as a caregiver. However, since her work day consisted of not only giving care, but also working within a bureaucratic system that frustrated her, she was having a hard time reconciling these two roles.

Beth was also concerned by the number of patients her practice was forced to turn away.

I don’t like to fight with folks so I try not to get stuck up front [at the reception desk], ‘cause it feels like there are days that we have to turn away more people than we take. A lot of ‘em are real angry when we give ‘em all the paperwork they have to fill out and tell ‘em we need proof of insurance before a doctor can see ‘em or we can set up an appointment…We’ve had a couple little girls workin’ reception quit ‘cause they got yelled at so much…We finally had to put up a big sign on the front door and another one in the waiting room tellin’ people we couldn’t give ‘em care if they didn’t have insurance, but it doesn’t seem to help (Beth, Interview 1).

Beth knew the practice’s physical location between two towns and close proximity to Highway 25 brought in individuals from several neighboring rural communities where she felt access to health care was likely inadequate. Due to the high number of uninsured individuals who sought assistance, Beth said a “rule” had been put in place which stated that patients were not allowed to be escorted to exam rooms until their proof of insurance had been verified. Although the practice had been known to make exceptions when they were presented with children with high
fevers or injuries, Beth said employees were told “The Rule” was created so that patients with insurance could receive the quality care they deserved. Administrators had also promoted “The Rule” as a measure designed to protect the staff and the practice from attending to clients who might not be able to pay for their services. Beth felt “The Rule” was a form of discrimination since ability to pay for services should not be based solely on the presence or absence of health insurance. Furthermore, she was unconvinced “The Rule” protected either clients or the staff. She believed the policy had been implemented to buffer administrators from staff complaints. “The Rule” created more work for the practice’s part-time office staff and forced sick or injured parties to spend extended unnecessary amounts of time waiting for assistance. This had resulted in several hostile exchanges between nurses and clients over the past several months. In many ways “The Rule” instituted by Beth’s employer reflects patterns in the national health care system which places the responsibility of accessing health care on the individual and control of the decision making process in the hands of private health insurance companies (Nguyen and Preshard 2003, Terris 1999).

Beth worried for the well-being of the individuals her practice was forced to turn away. “We have to tell ‘em to go the emergency room or a clinic or someplace else. And it’s not like that’s a good option either, because we know those people will probably have to wait a long time and probably not get the care we know they need” (Interview 1). Beth knew the emergency room would not give uninsured patients the care they needed, but she also felt that an emergency room would at least provide immediate care. Whenever possible, she encouraged the uninsured to use the urgent
care center located a few miles away or a clinic where she trusted the staff. Not only
did she feel clinics were more affordable, but she felt care and comfort were more
likely to be part of the experience.

Beth was sympathetic to the problems facing the uninsured, but she quickly
became frustrated by many of the practice’s regular clients. She was especially
irritated by clients who returned for follow-up visits because they did not follow their
treatment regimens. Her narratives frequently expressed her agitation with these
oftentimes confrontational patients:

There was a woman, who came in a couple weeks ago with a bad bronchial infection, and we gave her some antibiotics and then I
found out she was a smoker. I told her she needed to stop if’n she
wanted to get better. But she didn’t quit and she didn’t take her
medicine and she landed herself right back where she started. She
had the nerve to call the doctor “hateful” when he pointed out how it
was her fault. Maybe it was wrong to tell her it was “her fault”, but
she came to us and we told her what she needed to do to get better.
And then she didn’t do it. Now I don’t live under a rock and I know
how strong cigarette addiction is. And I know how hard it is to take
antibiotics like you should too, especially when you get to feelin’
better. I’m a nurse and I’m even guilty of that. But I kind of feel
like you can’t help people if they’re not willin’ to help themselves
(Interview 1).

Beth’s frustration with the woman came from her belief that the client was
noncompliant; the client was upset because she felt that neither Beth nor the
physician was sympathetic to her prolonged illness. Stacey and colleagues label this
form of interaction between health care professionals and their clients a “demanding
encounter” (Stacey et al. 2009). The “demanding encounter” acknowledges the
power asymmetry present in the practitioner/client relationship, however refocuses
some of that power into dialog occurring during the consultation as opposed to
placing blame on the behavior or belief systems of either party (Potter and MacKinlay 2005, Stacey et al 2009).

Even though Beth was critical of the client’s smoking, she also recognized smoking was an addiction and that people who tried to quit often failed. Beth also noted that instead of a high dose, short-term antibiotic regimen which was the preferred course of action for this type of infection, the physician offered the client a lower cost option which forced her to take a larger number of pills over a longer period of time. Beth admitted she was also guilty of forgetting to take antibiotics or suspending the treatment herself when she felt better, even though her professional training informed her otherwise. Beth’s admitted “non-confrontational” communication style left her tired and frustrated after “demanding encounters” with clients.

The Lines between Professional and Personal

At the time of our first meeting, Irene had been retired for a year and a half. Like Beth, Irene chose a career in nursing because she felt it was a profession that would offer her the opportunity to help people and possibly influence lives in a positive way. Irene also chose nursing because it was one of the few professional fields open to women when she finished high school. Irene’s nursing career provided her with a stable income, opportunities to travel, and a personal support network within her professional community. Irene had been married for a brief time in her early twenties and chose not to have children. She felt her career choice, which cast her in the role of caregiver, had shielded her from some of the gendered scrutiny that oftentimes accompanied her lifestyle choices. She described nursing as a “haven” for women.
like herself, and was proud of the close bonds she had formed with other women over the course of her career.

Irene began nursing school with the intention of becoming a labor and delivery nurse. She quickly became aware that many health care professionals pathologized the young female clients who sought prenatal care at the hospital and clinics where she trained.

I remember being so irate at my colleagues for calling these pregnant girls “dumb hillbillies” and making jokes about “teenage mountain mothers,” and I’m embarrassed now to admit how much I played along. But I have to say I spent the early part of my career crying a lot. Crying because I didn’t expect to see so many soul wrenching painful things when I made the decision to become a nurse and crying because I didn’t know who I was supposed to be (Irene, Interview 8).

As a student Irene felt her positionality as a woman from a mountain community challenged her new role as a professional. Although she felt a strong loyalty to the community where most of her family still lived, she also actively distanced herself from “mannerisms” which she thought might mark her as a mountain resident. She viewed her time in school as an opportunity to “improve herself” and took special care to take class notes which allowed her to improve her grammar and practice “complicated” vocabulary. She also made a conscious effort to lose her accent and became “hyper-aware” of any speech colloquialisms which signaled her mountain heritage. Irene was able to attend nursing school in Ohio because she had received a scholarship designed to provide opportunities for “disadvantaged women.” She knew there were other young women in her program from neighboring Kentucky communities who had received the same scholarship, however she felt the women
who were part of the scholarship program either consciously or unconsciously avoided contact with one another.

Irene returned to Kentucky after school, not only because she wanted to be closer to her family, but also because she felt she could return as a “hometown girl who made good.” She also felt the physicians and nurses who trained her in the urban clinics and hospitals where her school was located were “hostile” and “callous” to the problems facing the poor women who sought out their services. She believed if she returned “home” she would encounter health care professionals who were less judgmental and harsh. However, she was shocked to find that physicians in and around the community where she grew up participated in the same discourse as their urban counterparts.

When I was first starting out [working in a clinic] I remember dealing with a lot of young mothers and thinking they’re not much younger than me and if I had made different decisions with my life that could have been me. They came from the same kinds of communities I came from and were brought up in the same kinds of families. The physician’s back then were really cruel; this was at least thirty years ago, or more. They blamed these women… I actually I don’t think I’d call them women because a lot of them were still girls emotionally… They were treated like they had committed a mortal sin if they were young and pregnant or pregnant and unmarried. I guess in many people’s eyes they had [committed a sin], but it was just the social climate at the time” (Interview 8).

Irene’s connection to the young women she serviced was one of the reasons she described the early stages of her career in Kentucky as “stressful.” Irene’s narratives illustrate the conflicts she felt as she entered a professional world where a number of factors, including class and gender, influenced and justified who was entitled to care. Although she knew the slanderous insults colleagues used to describe their patients,
such as “villebilly whore” and “brother fucker,” were not directed at her, they were highly gendered and oftentimes community specific. These young women’s circumstances were used to reinforce stereotypes that mountain women were ignorant, flippant, and sexually promiscuous. These gendered insults served to take power away from young women who were already marginalized due to their impoverished circumstances (Shelby 1999, Engelhardt 2005). She also found that her new position as an educated professional forced her to occupy oftentimes contradictory roles in her home town. Irene described the sensation as “being a foreigner in [her] own life” since she felt her upbringing alienated her from other professionals and her education and time away from home changed her relationship with her family and her community. After her divorce Irene chose to leave labor and delivery, as well as eastern Kentucky, choosing to work in Lexington and Richmond for the remainder of her career.

While Irene did feel physicians were treating female patients and colleagues with more respect by the time she retired, she also wondered if this was a sincere appreciation for women or a product “of political correctness.” In her retirement, Irene found her training as a nurse aided in her new role as a full-time advocate and activist. In the later stages of her career she become actively involved with Planned Parenthood and at the time of our first interview was considering joining the Doctors without Borders program because she was dissatisfied with programs designed to assist Appalachian communities. Through her volunteer and advocacy/activist work Irene said she saw health issues which affected the poor magnified in a way she had never encountered these issues during her career. Social inequalities such as gender,
race, class or regional affiliation frequently manifest themselves in the discourse and practice which marginalize certain segments of the population as they explore their health care options (Mullings and Shultz 2006). Persistent health inequalities are just one visible example of a larger number of social inequalities present in the United States today.

Health inequalities, while fostered by institutional constraint, are an important part of a larger discourse on social inequality. Neither Irene, Beth, nor their colleagues, are technocrats who intentionally create and perpetuate health inequalities. However their acceptance or rejection of larger social attitudes does affect the roles they play as health care providers. Beth and Irene were both avid supporters of patients’ rights and both agreed that the U.S. health care system was heavily influenced by problematic discourses and practices including control by health insurance companies. Although each woman was committed to the practice of nursing with a biomedical context, they also felt the practice of biomedicine facilitated many of the problematic relationships they were forced to navigate on a daily basis. Beth and Irene were committed to the care giving philosophies of nursing which had led them to their career choices and felt that, despite the constraints placed on their profession from both inside and outside their immediate professional sphere, they were satisfied with most of the decisions they had made professionally. Both women agreed that nursing had left a memorable impact on each of their lives, and were saddened that more individuals did not make the decision to pursue a career in nursing.
Chapter Four

Conclusion

In the summer of 2009, health care, or more accurately proposed changes to the nation’s current approaches to health care, became a popular topic for discussion in the United States. The introduction of H.R. 3200, referred to in the media as “Obama’s Health Care Bill,” was received by the public with mixed emotions. Although many heralded the proposed legislation as move towards a more egalitarian and affordable health care system, many others were outraged and promised to resist the proposed changes. The language of personal choice and personal responsibility factored heavily into the discourses produced by those supporting both sides of the debate. Also linked to this debate was the belief that the decisions an individual makes in regards to his or her health, is and should be deeply personal. The debates surrounding proposed changes to health care policy also illuminated the lengths to which residents believed government interventions should be part of their decision making process. Framing health care as a “choice” or “freedom” subverts the ways in which contemporary racism, sexism, and class stratification influence who is allowed to make those choices.

The concerns connected to the current status of health care in the United States is reminiscent of the debate surrounding welfare reform in the mid-1990’s which resulted in the implementation of PRWORA. Central to each debate is the economic responsibility an individual has to themselves and other members of their local and national communities. Absent from each discussion is an examination of the social and political relationships which create continued constraint for those who are unable
to secure living-wage employment or those who have limited health care options due to restrictions imposed by private insurance companies. Each of these debates exists in a specific political moment, however each policy has had, or has the potential to significantly impact those living in poverty, the uninsured, or those who encounter discrimination based on their gender or race.

Through the narratives of women living and working in three Kentucky counties, I have tried to illustrate how the issues facing individuals who are forced to navigate each of these highly political terrains are exposed to environments mediated by similar relationships and circumstances. For those who rely on forms state-based public assistance, discourses of blame and responsibility reproduced on the local level allow all parties involved to ignore the larger structural issues which perpetuate the need for such programs. Caseworkers blame clients who participate in programs such as WIC or workfare for their inability to become economically independent. Clients in turn blame caseworkers for treatment they believe to be hostile, disrespectful, and judgmental. Clients also blame each other, creating divides between who is entitled to aid and who is not. Relationships in health care facilities function in much the same way, as health care professionals criticize clients who do not follow treatment regimens or become visibly angry and confrontational. Clients blame professionals for the bureaucracy they must navigate in order to gain access to care or for denying them the type and quality care they believe they have a right to receive.

It is my hope that this text also serves as a critical examination of the constraints faced by individuals attempting to access both public assistance programs and health care services. While the presence or absence of living-wage jobs or health care
facilities did create constraint for many of women I interviewed, issues connected to access were far more complicated than the presence or absence of physical structures. Camille, Leslie, and Amy were all currently employed at the time of their interviews, however their salaries did not provide enough income to support themselves and their children. Camille and Leslie had each participated in the workfare program, and each woman had been promised access to training programs and education which would improve their chances of securing stable employment. Leslie felt the training programs she was expected to attend as part of her participation in the workfare program did not help her find a job in a community where work was scarce. Because she had few employment opportunities in Jackson County, Leslie was commuting close to an hour everyday to work part-time for one of her mother’s friends. Camille had also not been able to rely on the resources workfare had promised, and found an alternative cosmetology school because the workfare supported school would not provide her with professional contacts. In both these cases workfare had promised access to resources that never materialized. Beth and Irene spoke at length about the way health insurance limited who was able to access desired medical care. Each woman had worked in communities where clients had been turned away due to their uninsured status. Many of their narratives revealed that the physical presence of clinics, private practices, or hospitals did not guarantee access to health care for many members of their communities. Insured or uninsured status played a significant role in the type of care individuals’ were granted, however overcrowded facilities and overworked employees also influenced the quality of care the uninsured received.
Although the essays contained in Judith Goode and Jeff Maskovsky’s collected volume *The New Poverty Studies* (2001) were written as an ethnographic response to late twentieth century U.S. domestic and foreign policy, including the North American Free Trade Agreement (NAFTA) and PRWORA, market triumphalism, economic polarization, and political demobilization are still valuable frameworks. While the importance of economic stability should not be underscored, market triumphalism creates a climate where an individual’s aptitude for “success” is based in their ability to become economically prosperous. For women such as Leslie, Ashley, Camille, and Amy - whose lives has been disrupted by divorce, loss, and relocation – their participation in public assistance programs perpetuated a cycle of economic polarization since the employment opportunities and aid they received from these programs did not help them secure stable employment. These women also experienced economic polarization since their part-time, low-wage positions did not afford them the opportunity to accrue savings which could provide economic protection during future uncertainties. The discourses of blame which located each woman’s reliance on public assistance to her inability to fulfill her social roles as a worker and as a mother served as a form of political demobilization. Leslie and Ashley’s narratives which focused on who was entitled to aid and who was not also served as a form of political demobilization. Because Leslie and Ashley saw their circumstances as “temporary” - while accusing others intentionally used public assistance as a form of work avoidance - they were unable to critically examine how the discourse of blame and responsibility was used to marginalize all WIC recipients.
Beth and Irene’s narratives, which focused on the frustrations they experienced as health care professionals, followed many similar themes. Beth, Irene, and many of their colleagues were politically demobilized in the sense that although they understood that health insurance companies controlled an interest in the types and quality of care they were allowed to administer, they were uncomfortable conceptualizing alternative long-term options. Even though they were able to circumvent the system in some instances – such as giving pharmaceutical samples to clients who could not afford high priced prescriptions – these strategies did not assist those who were unable to gain access to facilities as a result of their uninsured status. The uninsured are economically polarized since the fees-for-service associated with the United States private health care system are frequently absorbent. These problems are compounded for individuals who are unemployed, are part-time or seasonal laborers, work for employers who do not offer benefits packages, or are not eligible for insurance due to pre-existing conditions. Finding health care facilities which serve the insured is also complicated, since private practices such as Beth’s employer, are able to deny care without proof of health insurance.

The timing of the current health care debate was ironic as I struggled to organize data on a project that frequently produced more questions than answers. Although the initial intention of this project was to explore how one specific incident effected women’s access to health care and health care facilities in a small Kentucky town, it eventually evolved into a project which explored the social determinants of health as well as the ways in which women hailing from diverse backgrounds and experiences understood poverty, privilege, and health care. Jackson County, one of the counties
where I conducted my research, is currently listed as one of the one hundred poorest counties in the United States (US Census Bureau), as are many of the other counties in eastern Kentucky where my informants still have family and loved ones. Beth and Irene each agonized with the decisions they had made to leave impoverished communities they knew lacked access to health care professionals and adequate health care facilities. Each woman talked at length about the ways their career choices had exposed them to underserviced members of the population and the guilt they felt for leaving the communities where they had been raised in order to find better paying jobs. Although Leslie was optimistic that her job options in Jackson County would improve, she struggled to articulate what those options would look like and where she saw her life in the future.

While I hope many of the themes I uncovered over the course of this project will provide the framework for future research, I am also reminded of how vastly complicated discourses on health care are for U.S. residents. The topic of health inequalities cannot be viewed as series of isolated events and must be linked to a larger discourse on social inequality. The health care system in the United States provides a unique perspective to explore topics such as privatization, access to care, and the decision making process, however these issues must also be linked to discourses on individual choice and responsibility. I believe I can use what I learned from this project to construct future lines of inquiry which continue to critically examine the social relationships and institutions which construct and maintain health inequalities. It is also my hope that in this space in time where health care has
become a deeply political and highly publicized issue, issues connected to access can become not just topics of discourse but spaces for action as well.
APPENDIX 1 – BASIC DEMOGRAPHICS

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<thead>
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<th>Source</th>
<th>County</th>
<th>Age</th>
<th>Marital Status</th>
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<th>Educational Attainment</th>
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<td>R</td>
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</table>

8 Primary sources have pseudonyms and secondary sources are labeled alpha-numerically
9 M=Married, D=Divorced S=Single
10 Highest educational level attained, some participants attended college without completing degrees
11 O=Home Owner, R=Renter, F=Lives with family
# APPENDIX 2 – HEALTH DEMOGRAPHICS

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</table>

¹² Primary sources have pseudonyms and secondary sources are labeled alpha-numerically.
¹³ U=Uninsured P=Public (Medicaid/Medicare) E=Private (Employee based or individual policy).
¹⁴ All women in the sample who received public assistance were WIC recipients.
¹⁵ Do women have a primary care physician (Y or N)? Where do women seek care? GP=Private physician, C/ER=Clinic or ER, C=Clinic or Walk-in Physician.
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Williams, B.
VITA

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Primary Instructor: Anthropology 160 (Summer 2009)
Primary Instructor: Arts and Sciences 100 (Fall 2009)
Primary Instructor: Anthropology 101 (Spring 2010)

Scholastic and Professional Honors:
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