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Latino Immigrant Workers’ Search for Justice After Occupational Injury

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Latino Immigrant Workers’ Search for Justice After Occupational Injury

by

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A thesis submitted in partial fulfillment of the requirements for the degree of
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Abstract

Latino immigrants encounter an entanglement of rights and policies after occupational injury or illness. In collaboration with an immigrant worker center, ethnographic research and a survey are used to analyze injured workers’ experiences. The center uses survey results to identify common threads and systematic problems, and to explore potential direct action. Through interviews with workers and medical and legal professionals, I investigate the barriers Latino immigrants face following occupational injury or illness, how their lived experiences relate to the greater medicolegal frameworks that demarcate most formal processes of compensation and treatment, and the experiences of professionals who mediate these structures. Research results confirm that immigrant workers lack information about their labor rights and the workers’ compensation system, which prevents them from filing claims, and contributes to the underreporting of workplace injuries. However, this research project also documents how workers who do file claims and report injuries are systematically barred access to redress due to a confluence of factors including unresponsive and fraudulent employers, biases in the medical system, discourses of deservingness, insufficient protections from retaliation, and the effects of a market-based medical system. I argue that future work-related injury prevention efforts should go beyond rights education, and include reforms to the compensation system.
Chapter One: Introduction

On March 21, 2006, 20-year-old Edgar Velazquez, an undocumented immigrant from Mexico, was working for a tree servicing company in Providence, Rhode Island, when he accidentally slashed his face open with a chainsaw. In August, after emergency reconstructive surgery and learning he was entitled to workers’ compensation benefits, he appeared at his scheduled workers’ compensation hearing at the J. Joseph Garrahy Judicial Complex. He was arrested by immigration agents before entering (Ziner 2007).

Edgar’s case dramatically illustrates the entanglement of rights and policies that immigrants encounter after occupational injury or illness. His detention unfurled at the same time court officials were encouraging Latino immigrant workers to trust the court system and reduce the fear of filing a claim. And at a time of increasing criminalization of immigrants, it also catalyzed community leaders and advocacy organizations to provide public support for Edgar’s release and fair compensation. Engaged dialogue had positive results, including the creation of a buffer zone on the steps and within the courthouse that would prohibit the presence of Immigration and Customs Enforcement (ICE) agents. Yet, while Edgar eventually won his case and received compensation, his trajectory deviated from the clear procedures depicted by a cursory read of the laws governing workplace safety protocols and outlining the workers’ compensation system. His employer, William J. Gorman, Jr., had no workers’ compensation insurance policy, and some speculated that Gorman might have called ICE himself. At work, Edgar’s pleas for safety equipment were routinely not heeded, and his supervisor was verbally
abusive. Immediately after the accident, Gorman had attempted to deter Edgar’s co-worker from calling 911 despite the gravity of his injuries. After the trial was decided, Gorman filed for bankruptcy and left part of his obligation to Edgar unfulfilled. Unfortunately, the challenges Edgar faced at work and post-injury are not uncommon in low-wage immigrant communities.

On a global scale, immigrants work more dangerous jobs and suffer from occupational injury and fatality at greater rates than native-born workers in the same industry sectors (Byler 2013; McCauley 2005; Schenker 2010). In the US, between 2003 and 2006, the fatality rate for foreign born Latino workers was 48 percent higher than the rate for all workers and yet occupational injury and illness rates are likely to be undercounted for this population (Cierpich, et al. 2008; Flynn 2014). Notwithstanding an elevated risk of occupational injury, Latino workers face many barriers seeking legal aid, medical attention, or compensation post-injury. Additionally, their inability to file workers’ compensation claims and for those to be accepted by the court is public health concern. In 2007, for example, the total medical and productivity costs of occupational injuries and illnesses was $250 billion, greater than the estimated cost of cancer nationwide (Leigh 2011). Workers’ compensation covered less than 25 percent of these costs, and the rest of the costs are shifted to members of society, albeit unequally. Latino workers are one population more likely to “shoulder the financial burden of recuperation” from workplace injury (Gleeson 2012b:2292).

This study investigated injured Latino immigrant workers’ experiences after work-related injury and illness. Additionally, I sought to contribute to emergent research on immigrant workers’ attempts to seek redress through the workers’ compensation system and community-based activism (Benson 2008; Holmes 2007; Holmes 2011; Quesada 2011; Saxton 2013; Willen et al. 2011). This research “highlights the body as a site of inscription of politics” (Castañeda
2010:6) and by studying how work-related illness is contested in the workers’ compensation system, also explores claims of health-related deservingness and legitimacy (Fassin 2001; Willen 2012). This will be discussed in further detail in chapters to follow. Additionally, the present study also contributes to the sparse anthropological literature on immigrant worker health in industries outside agriculture (Gleeson 2012).

I conducted this research in partnership with Fuerza Laboral/ The Power of Workers, a worker center located in Central Falls, Rhode Island, which organizes around injustices that affect injured Latino immigrant workers. Fuerza Laboral was founded in 2006 and has prioritized providing training in labor rights and direct action organizing techniques to the Latino immigrant community. Fuerza Laboral’s name plays on the double meaning of the phrase in Spanish to emphasize how immigrants are literally the backbone of the “workforce” and to highlight the “power” workers have to change and disrupt unjust systems. The organization has championed popular education, justice for immigrants, and wage theft campaigns. Additionally, the center also sponsors an Injured Workers Committee, which provides a space for injured workers to act as leaders and organizers in the movement to make the Rhode Island workers’ compensation system more equitable and accessible.

Injured Workers Committee leaders and Fuerza Laboral’s director requested collaboration on the survey component of this study and supported the research goals from inception. Worker leaders and I surveyed twenty injured workers who had sought help from Fuerza Laboral in the past year, or who were currently active members of the Injured Workers Committee. Twelve of those surveys were also accompanied by semi-structured interviews with the participants. Interviews were also conducted with three legal professionals, and four medical professionals who interact with injured workers through the course of their job.
Results demonstrate gaps in existing systems for redress and support during injury, unsafe work environments, lack of information and fear of retaliation as deterents to filing a workers’ compensation claim. Challenges regarding language access when seeking legal representation and healthcare, problems with requirement of preauthorization, and the high cost of services were identified as deterents for seeking medical attention. Major findings illuminate that even while there are deterents to filing claims and reporting injuries, those injured employees who do file claims or report injuries face multiple levels of challenges and resistance. These circumstances highlight power differentials between workers, the importance of employers’ cooperation, and the need for systems that are more sensitive to structural barriers. Additionally, findings underline the compensation system as another field where Latino immigrants fight to be considered “deserving,” and the role of bias and stigma within such evaluations (Willen 2012).

Utilizing activist research methodologies, this study sheds light on a major source of structural violence in immigrant workers’ lives (Pulido 2008). The survey is a crucial part of how this study will meet the activist research aim of reciprocity. Deepened engagement allows researchers to develop a correspondingly profound understanding of the research context that “has the potential to yield privilege insight, analysis, and theoretical innovation that otherwise would be impossible to achieve” (Hale 2008:20; Speed 2008). Because this already organized community conceptualized the survey, this research project contributes tangibly to the organizations’ goals (Pulido 2008). The paucity of information about immigrant occupational illness or injury experiences also affects community-based service providers and local regulatory agencies charged with upholding occupational health standards (Panikkar, et al. 2012). Working with worker leaders at Fuerza Laboral, this study’s results will be used to create deliverable
documents, guides, and/or reports for these organizations and agencies. The potential impact of this study relies on its basis of collaboration with community-based activists, those responsible for most gains in rights and justice for im/migrant workers (Abrams 2001; Benson 2008; Singer 1995; Smith-Nonini 2011).

The objectives of this thesis are as follows:

1. Analyze workers’ experiences of occupational injury and the workers’ compensation system, including challenges they face, and how their experiences relate to the medico-legal policy framework.

2. Analyze medical and legal professionals’ experiences within the workers’ compensation system, including their perceptions of immigrants’ occupational health issues, and what challenges and ethical dilemmas they faced with working with injured immigrant workers.

3. Explore how workers perceive medical and legal professionals who mediate their experiences.

4. Identify what challenges are shared by multiple survey participants, and potential direct action and policy change campaigns for the Injured Workers Committee.

Like preceding studies of im/migrant workers, data from this project also sheds light on issues central to applied anthropology, such as social inequality, globalization, conceptualizations of identity, community, the culture of biomedicine, and the intersections of immigration, labor and health care policy (Castañeda 2010; Fassin 2001; Holmes 2012).

Ultimately, this project also contributes to a more nuanced understanding of agency for structurally vulnerable groups. By documenting workers’ experiences in seeking redress post-injury from employers, this project connects the existing literature on (re)production of Latino
immigrants’ vulnerability to actions that could support disassembling exploitative structures (Holmes 2011; Quesada, et al. 2011; Saxton 2013).
Chapter Two: Research Setting

Historically a mill town, Central Falls, Rhode Island, now is home to a diverse community employed in a variety of non-agricultural industries including manufacturing, construction, waste management, and the service sector (Labor Market Information Unit). Thus by way of this geographical focus, this research project addresses the relative paucity of research on industries outside of agriculture in existing anthropological literature on immigrant worker health (Gleeson 2012). In 2013, the population of Providence County was 628,600 people, consisting of 65 percent White, 20 percent Hispanic or Latino, 11.1 percent Black or African American, and 4.2 percent Asian. In comparison, the population of the city of Central Falls was 19,416 people, consisting of 5.6 percent White, 60.3 Hispanic or Latino, 10.1 percent Black or African American, and 0.6 percent Asian. In March 2008, with resentment targeted at immigrants growing as the economy spiraled into recession, Republican Governor Donald L. Carcieri issued an executive order allowing state police to act as immigration officials, finding and detaining undocumented immigrants, and enforcing the use of E-verify in all executive offices (Bernstein 2008; Fitzpatrick 2014). Though the executive order was rescinded in 2011, it has taken a toll on the Latino community, inspiring fear and generating vulnerability in communities like Central Falls. A rise in sudden detentions and workplace raids reverberated around the city and state. In Central Falls, a detention facility in its own backyard complicated the city officials’ relationship to the 60 percent Latino majority population, while it ostensibly generated income for the municipality (Bernstein 2008; Fitzpatrick 2014). Such hostile environments affect occupational safety for immigrant groups by limiting their agency and
criminalizing their experience, as “laborers’ perceptions of whether they are locally socially accepted influence important life decisions such as whether to seek health care” (Quesada 2011:390). In fact, Edgar Velazquez’s case, described in the introduction, is indicative of how occupational injuries among immigrant communities had gathered attention in the area even before the crackdown. I expand the anthropological perspective on these issues by contributing to the budding area of research centered on immigrant workers’ attempts to seek redress through the workers’ compensation system and community-based activism (Benson 2008; Holmes 2007; Holmes 2011; Quesada 2011; Saxton 2013; Willen, et al. 2011).

Worker Centers and Fuerza Laboral

The struggles of immigrants coming to the United States only to face discrimination and exploitation is well known. Yet, more recent waves of immigrants face the particular barrier of not having authorization for residency or to work. Previously, immigrants and other disenfranchised groups were able to form unions and expand labor protections like higher wages and fairer practices. Now, immigrants working in the lowest paying job markets in the country are forming new types of organizations, such as worker centers, to fill these gaps. Janice Fine (2006) outlines three approaches that worker centers might employ in their struggle for dignity for low-wage workers: service delivery, advocacy, and organizing. Service delivery can include legal assistance, the provision of information materials, or more broadly, connecting workers to different resources such as health clinics. Advocacy work might include conducting research about the conditions in the low-wage job sector, lobbying for legislative changes that support labor and immigration rights, or working “with government agencies to improve monitoring and grievance processes” (Fine 2006: 12). Organizing involves a focus on leadership development and seeks to provide avenues for workers to take action to impact the labor market through
policy reform or direct economic action (Fine 2006: 12). As part of a greater community-based labor organizing movement, immigrant worker centers provide avenues for marginalized communities to reclaim an active position in civil society and exercise political power (Fine 2006).

Fuerza Laboral / The Power of Workers (Fuerza) is a worker center organizing against labor exploitation and to protect the rights of workers in Central Falls, Rhode Island (Fuerza-Laboral 2013). Fuerza grew out of advocacy and organizing group United Workers Committee (UWC), which begun meeting in 1994 as a part of the more service-oriented Progreso Latino group. As a hybrid organization, they focus on grassroots leadership building in communities that are most affected by labor law violations, but also participate in advocacy campaigns and provide some limited referral services. Based just outside of Providence, Rhode Island, the organization is heavily involved with the Latino community. With an emphasis on direct action, the organization defines itself in opposition to service providers and advocates; they prioritize testimony and leadership directly from affected workers (Fuerza Laboral). Their staff consists of an organizer and an executive director, and a part-time development team member. Their work is grouped into four major campaigns, the Campaign to End Wage Theft, the Injured Workers Committee, Justice of Immigrants, and Popular Education and Leadership Training. For this project, I collaborated with the Injured Workers Committee. This committee is composed of male and female Latino immigrants of various nationalities and varying documentation status. Much of the work of the Committee in recent years has involved organizing workshops where community leaders share their experiences with the workers’ compensation system and educate workers about the rights regarding a safe workplace (Fuerza Laboral). For the last two years, these workshops included a three-part session in collaboration with the chief judge of the
workers’ compensation court, as part of an initiative to train new community leaders in the procedures and protocols of the medico-legal compensation system.

*The Rhode Island Workers’ Compensation System*

In the first half of the twentieth century, workers’ compensation systems developed alongside other labor protections, such as minimum wage protections, and collective bargaining rights, with Wisconsin being the first state to pass a workers’ compensation law in 1911 (Gleeson 2012a; Guyton 1999). Characterized as a “great compromise,” the system was considered innovative for its “no-fault” insurance paradigm. Previously, employees who were injured at work due to negligence or employer liability were able to sue their employers, but if an employee committed an error or if no party was responsible for the accident, then employees were left destitute, unable to work and unable to pay for medical attention. As the term implies, the “no-fault” insurance scheme removes the need for responsibility to be decided, and an employee who is injured in the course of their work is entitled to compensation, regardless of circumstances. This benefits employers, who are no longer subject to pay for suffering and damages, as well as employees, who have the right to medical attention and financial support in the form of disability benefits paid by the employer’s insurance (Guyton 1999).

In the 1970s and 1980s, workers’ compensation reforms were common across the country reaching a crisis in the early 1990s. McCluskey (1998) describes the fiscal crisis for compensation systems as involving three key problems. First, were the rising workers’ compensation insurance rates rising throughout the two decades. The second program arose when in some states some private insurers refused to continue to provide coverage without raising prices. Thirdly, there was a disjointed increase in insurance premiums, as the higher rates charged to employers did not translate into higher rates or better compensation for workers nor
into safer working conditions (McCluskey 1998). Thus while employers and insurers held that costs of benefits were reaching crisis levels, labor groups and advocates or injured workers maintained that benefits remained insufficient “to prevent destitution and despair for many workers,” and in fact benefits and coverage “remained well below recommendations for minimum adequacy set unanimously by the 1972 National Commission [on State Workmen’s Compensation Laws]” (McCluskey 1998: 698). In 1989 the insurance industry interest groups initiated a campaign across the nation to reform the laws governing workers’ compensation benefits. Pushes for legislation intended to undo the austere effects of such policies followed (McCluskey 1998: 707). Judge Ragan, interviewed as part of this research project, was fairly involved in these discussions and described this as a time of constant and dissatisfied change.

In the 1980s, there was a lot of debate—philosophical, realistic, practical debate—about how the compensation should proceed. They were so frustrated, and it was both sides, labor and business where so frustrated with the way the compensation system was working that they were passing sweeping compensation reforms every two years. Creating state departments, eliminating state departments, ostensibly eliminating lawyers.

In Rhode Island, such debates culminated in the 1992 reform of the workers’ compensation system. These events are significant because they underscore the great efforts and compromises that were needed from various factions to arrive at the current system, but also highlight how major reforms or reflection about the compensation system have not taken place for decades. The 1992 reforms introduced fairly distinctive and innovative facets to the policy, in comparison to other state programs. These include a general Advisory Council, a Medical Advisory Board, an outpatient treatment center, an educational unit, and integration with the Temporary Disability Insurance (TDI) program. These features are further discussed below. Generally, Rhode Island has resisted ongoing pressure from those representing employer and insurance interest to reduce benefits paid to workers, and the current system can claim
accomplishments in some metrics (Grabell and Berkes 2015). For example, it has controlled medical costs better than neighboring states, and reduced some bureaucratic barriers by instituting deadlines for pre-trial hearings for injured workers (Backus Hall 2014; Sollosy and Nee 1995). In 2014, medical costs in Rhode Island made up only 25 percent of total benefit costs related to workers’ compensation, whereas in the entire Northeast Region, medical costs made up an average of 56 percent of the total benefit costs. While lowering reimbursement rates for physicians is also promoted as a mechanism to limit medical spending, higher reimbursement rates in Rhode Island have instead been associated with reduced medical costs (Backus Hall 2014). Rhode Island offers Maximum Allowable Reimbursement (MAR) rates greater than 200 percent the Medicare reimbursement rate (Lipton, et al. 2010). Judge Ragan credited such policies with allowing and encouraging a greater variety of physicians to continue participating in the system, and for preventing the system from pushing doctors to over-treat and over-test. The Rhode Island system also includes other unique features.

Alongside a general Advisory Council, the system includes a Medical Advisory Board made up of physicians of varied specialties. The Board approves different insurance providers’ Preferred Provider Networks (PPNs), as well as related protocols. PPNs list the in-network providers that an insurance company will allow their clients to see for reimbursable conditions. The Advisory Board assures a certain variety and amount of specialists and physicians are available on each network, oversees which physicians are available to perform court-ordered Impartial Medical Exams (IMEs), and establishes guidelines for such exams. Additionally, Rhode Island is one of five states that operates a state-run Temporary Disability Insurance (TDI) program, and the Workers’ Compensation law allows injured employees to receive payments
under TDI without incurring a lien, even when their case is resolved through settlement (Social Security Administration).

Rhode Island law (Gen Law 28-33-19) grants additional compensation for scarring, disfigurement, and loss of use in addition to weekly benefits. Scarring and disfigurement can be anywhere on the body to qualify for compensation, not solely on the extremities and face, as in other states such as Massachusetts. Rhode Island offers weekly wage-loss benefits at 75 percent of the weekly salary or base wages before injury if an injured employee is not working at all post-injury (RI Gen. Law 28-33-18). The Rhode Island law also includes a right to reinstatement that requires employers to make “reasonable accommodations” to help injured employees under certain conditions return to his or her former position (RI Gen. Law 28-33-47). An injured employee has a right to reinstatement if he or she had been working for an employer with at least nine employees, if he or she “sustained a compensable injury,” and if he or she claim their right within ten days of when their physicians notified them by mail that they were released for work. If the past position is unavailable, injured workers have a right to “any other existing position that is vacant and suitable” (RI Gen. Law 28-33-47). Workers are not covered under the law if they had only been working there during a probationary period, if they were working under a temporary basis, or worked for an employer with nine or fewer employees. The right to reinstatement ends one year after the injury, or “30 days after an employee reaches Maximum Medical Improvement (MMI)”. It is extended to 18 months after an injury if a worker is participating in an approved rehabilitation program, and several other exceptions and provisions also apply (Education Unit). So while workers who meet all these specifications may be able to demand their job back from their former employer after recovery, but those who do not qualify are left with few options.
Rhode Island has no exceptions to the employment-at-will doctrine. The employment-at-will doctrine allows employees working without a contract to be fired without a cause. Most states, however, also have a public policy exception to the doctrine that would designate an employee as wrongfully discharged when the termination violates other established public policies. For example, this would prevent an employer from firing an employee for refusing to break the law, or “for filing a workers’ compensation claim after being injured on the job” (Muhl 2001:4). Rhode Island is one of seven states to reject this exception. Additionally, no part of the workers’ compensation law explicitly prohibits retaliation for filing a workers’ compensation claim, and no other protections are extended to workers who are excluded from the right to reinstatement. Injured workers would technically be able to file a whistleblower’s suit outside the workers’ compensation court system (RI Gen. Law 28-50-1).

In 1990, Beacon Mutual Insurance was chartered as “nonprofit independent public corporation for the purpose of insuring employers against liability for personal injuries for which their employees may be entitled to benefits under” workers’ compensation law, and designed to help reduce claim costs, and which now reports covering 60 percent of the workers’ compensation market in the state (Beacon Mutual Insurance). The Rhode Island Workers’ Compensation Act also establishes the Donley Center, a “non-profit outpatient facility” providing a concert of services including case management, a variety of therapy and counseling, as well as trainings and workshops (RI Gen. Law 28-38-19). Injured workers who have filed a claim are eligible to receive services free of charge, but must be referred to the center by their treating physician (Rhode Island Department of Labor and Training). The system also counts on an educational unit that generates brochures about complex legal topics, and seeks to prevent
injuries by informing employees and employers about their respective responsibilities (Sollosy and Nee 1995).

The Rhode Island Workers’ Compensation Act applies to employees, who are defined as “any person who has entered into the employment of or works under contract of service or apprenticeship with any employer” (RI Gen. Law 28-29-2). In Rhode Island, this definition has been interpreted to include undocumented employees. At least 19 states have adjudications that explicitly state that immigration status does not affect a claimant’s eligibility for workers’ compensation, and one state, Wyoming, has explicitly denied undocumented workers access to workers’ compensation (Wyom. Stat. Ann. § 27-14-102, Smith et al. 2011). In 2007, the Rhode Island Uninsured Employers Fund was also instituted by law, which is intended to provide funding for an injured worker’s benefits—including counsel fees but excluding disfigurement and loss of function benefits—if and when his employer did not maintain workers’ compensation insurance (RI Gen. Law 28-53-7). However, as Judge Ragan acknowledged at a workers’ compensation training at Fuerza Laboral, this fund remains essentially empty and unable to provide support for workers.

An overview of some of the key procedures and stages of the compensation case, as intended by law, follows. If an injury requires medical attention or incapacitates a worker for at least three consecutive days, the injured worker is responsible to report their injury to their employer. The employer is then required to complete a report for the Department of Labor and Training’s Division of Workers’ Compensation within 10 days of knowledge of the injury and file a claim with the employer’s insurance carrier. The insurance carrier could at that point deny the claim, accept the claim, or act under a non-prejudicial agreement, which would mean they did not fully accept liability for the injury but will pay weekly benefits for the injured employee.
for up to 13 weeks, after which they may discontinue payments. Insurance carriers are required to let employees know when benefits are terminated and when a claim was not formally accepted after a non-prejudicial appointment (RI Gen. Law 28-35-8). Employees then have two years to submit a petition to establish liability of the employer or insurer formally (RI Gen. Law 28-35-57). Workers’ compensation benefits include weekly wage replacements and cover medical costs for workers who experienced partially or totally incapacity. In Rhode Island, maximum weekly compensation is set to not exceed 115 percent of the state average weekly wage, and is scheduled to increase to 120 percent in October 2016 (RI Gen. Law 28-33-17). Temporary Disability Insurance “provides benefit payments to insured RI workers for weeks of unemployment caused by a temporary disability or injury” and Permanent Disability Insurance consists of cash payments administered by the Social Security Administration (SSA) to claimants who are deemed “disabled and/or blind as defined by the Social Security Act” (Office of Rehabilitation Services). As discussed previously, injured workers may also receive compensation for loss of function and disfigurement.

Before a case proceeds to trial, a mandatory pretrial conference is scheduled twenty-one days from when the claim was filed with the court. At this trial, the judge evaluates the merits of the case, and makes a decision that becomes effective immediately. The pretrial conference does not include oral testimony and is less formal than a full trial. Either party must file an appeal on issues not resolved and agreed upon in the pretrial within five business days to enter a full trial. An initial hearing is then scheduled within thirty days. The initial hearing serves to address uncontested issues, as well as to schedule witnesses and other testimonies. Judge Ragan estimates that of an approximate hundred thousand workers’ compensation cases filed each year
in Rhode Island, the court only sees about eight thousand. Of those eight thousand, over 70% are resolved at that the pretrial stage of the proceedings (Rhode Island Court System).

After the initial hearing, the merits of the claim can be further disputed on two bases. One is whether the injury qualifies under the exact specification of the law. For example, injuries coming and going to work are not covered under workers’ compensation, and independent contractors are not eligible for coverage and benefits from their contractor’s insurer under workers’ compensation law. The other main category of contestation revolves around the claimant’s credibility; arguments that “the employee should not be believed for some reason” (Interview with Chief Judge).

From then on, decisions on benefits are made following medical evaluations and other evidence presented by lawyers. Throughout this process, injured workers may be asked by the insurance carrier to visit a non-treating physician for an independent medical evaluation. If there are discrepancies between the two doctors’ evaluations and recommendation, the court may ask for an injured worker to visit another physician for a court sponsored impartial medical exam (IME). Two different types of evaluations are made, degree of functional impairment evaluations and designation of temporary or permanent disability. Functional impairment is considered a medical and “demonstrable finding” based on the American Medical Association’s Guide to the Evaluation of Permanent Impairment (RI Gen. Law 28-29-2).

Disability is a related categorization, but one that takes an injury’s context into account. For example, except for specified injuries, like the loss of sight in both eyes or the loss of both hands, “total” disability is determined when an employee proves, taking into account the employee's age, education, background, abilities, and training, that he or she is unable, on account of his or her compensable injury, to perform his or her regular job and is unable to perform any alternative employment (RI Gen. Law 28-33-7).
If a worker receives incapacity benefits, there are additional medical reviews and impartial medical exams they will be asked to attend, at 26 weeks of benefits, and repeated every 13 weeks afterwards, in addition to a yearly anniversary review. Benefits are suspended or reduced under a number of different conditions, including if employees discontinue receiving medical care deemed necessary, reach maximum medical improvement (MMI), or if they return to work (Rhode Island Department of Labor and Training).

Overall, the system was designed to balance complex and often seemingly contradictory interests of insurers, employers, and injured workers themselves. Rhode Island’s system has addressed issues of cost containment in creative ways, and has steered away from cutting benefits and reimbursements in order to reduce expenses. Throughout the following chapters relevant aspects of the legal system and its interactions with other policies and systems will be further expounded.
Chapter Three: Literature Review

Medical anthropology’s study of immigration has waxed and waned in popularity but dates at least as far back as to Franz Boas and his craniometrical research on Southern and Eastern European immigrants to the United States in the early 1900s (Chavez 2003). His research set the stage for a tradition of anthropological work that challenged public perceptions and commonsense beliefs about immigration and immigrants. In that time, Boas’ research discredited purportedly natural associations between immigrants’ physicality and intellect, morality, and potential. Instead, his conclusions supported explanations that named environment and nutrition as stronger determinants for so called “racial characteristics” (Chavez 2003; Kraut 1994). Anthropological research on immigrant living and working conditions can be traced back to the 1920s when Manuel Gamio (1931) collected narratives from Mexican workers that contained information about unhealthy working conditions and barriers to integration (Chavez 2003; Gamio 1931). The history of social medicine is also tied to occupational health. The concept of social medicine connects medicine to politics, and disease to socioeconomic conditions. The discipline focuses “on topics such as the social and economic structure of health-care provision, health policy, and clinical holism … such as concerns with doctor/patient relations in culturally diverse societies” (Porter 2006). In 1848, Rudolf Virchow, then a young physician shocked by the living and working conditions of mining communities in Silesia, a region mostly located in Poland today, was catalyzed to criticize government and industry for placing capital concerns above those of labor, “crystalliz[ing] the concept of social medicine”.
These initial anthropological interests in immigration were diminished largely in part to anthropology’s self-identification as a discipline which prioritized the study of indigenous communities and the “other” and the neglect of research located in the United States. In short, US migration studies became a central focus for sociology and other disciplines. Yet, in response to the relocation of their traditional participants, and the growing immigrant populations in the US, contemporary anthropologists have swiftly established a body of work that demonstrates the unique contributions that anthropology can bring to the study of immigrant health and that demonstrates what can be gained for the field of applied anthropology in engaging with these topics (Castañeda 2010; Chavez 2003; Seif 2005).

In consideration of the tendency within the health sciences to focus on individual choice and behavior, applied medical anthropologists’ role in augmenting the scale of what factors are considered when studying issues of labor, immigration, and health is of paramount importance and consequence. Employing political economy, phenomenology, and the concepts of structural violence and vulnerability, anthropologists have questioned the impetus of migration and immigration as well as neoliberal environment that come to produce substandard conditions for immigrant emotional and physical injury (Benson 2008; Green 2011; Holmes 2013; Saxton 2013). This study relies on previous work that critically investigates im/migration as a foundational facet of the immigrant worker experience. Anthropologists have identified causal connections between trade policies such as the North American Free Trade Agreement (NAFTA) and the Central American Free Trade Agreement (CAFTA) and the increases in displaced workers and farmers in Mexico and Central America, and the positioning of the United States as “a magnet for cheap, exploitable, and illegal migrant labor” (Green 2011:369). Focusing on
undocumented migration from Guatemala, Green (2011) exposes the scope of these policies by noting the vicious ironies embedded in how neoliberal policies structure the Guatemalan economy such that 75% of the workforce labors in the informal sector. These superfluous people, or “nobodies,” are then transformed into the dispensable cheap labor that powers the American economy upon crossing the border (Green 2011; Smith-Nonini 2011). This literature demonstrates the importance of understanding labor and occupational health in the context of immigration and transnational policies (Green 2011; Smith-Nonini 2011).

Globalization has encompassed amplified and diversified international flows of labor with few constants besides a majority of immigrants being “employed in what have come to be known as ‘3-D’—dirty, demanding, and dangerous— jobs” (Flynn and Eggerth 2014: 377). In the US, a dramatic increase in immigration from Latin America in the last two decades has been accompanied by widening disparities in occupational health. Latino workers born abroad have greater rates of fatal work-related injuries than US-born Latinos and Latinos in general are affected by even greater rates of nonfatal occupational illness than the average for all workers (Flynn and Eggerth 2014; Richardson, et al. 2003). Complementing already alarming statistics, others have used community-based surveying to show that some types of occupational injury and illness among immigrants are underreported (Azaroff, et al. 2003). There are many factors that affect why foreign-born workers may be at greater risk for occupational injuries and less likely to file claims, including language and cultural barriers, fear of retaliation, and lack of knowledge about existing systems (McCauley 2005; Walter, et al. 2002).

Occupational injuries in the US have declined by 67 percent since 1970, with the Department of Labor documenting 4,383 workers killed on the job in 2012 (Occupational Safety and Health Administration). This decrease seems heartening, but considering that “work-related
injury and disease is socially produced, and can be prevented,” these numbers remain an alarming phenomena (Abrams 2001:37). In one study of injured Australian workers, for example, many injured female workers were able to identity faulty or broken equipment, the volume and speed of work, a lack of breaks, frequent short-staffing, and supervisorial monitoring as aspects that contributed to their repetition strain injuries (Ewan, et al. 1991; Reid, et al. 1991; Walter, et al. 2002). Latino immigrants working as day laborers have also reported lack of training or experience with their assigned duties, substandard equipment, and the hazardous effects of economic pressure that coerce them to skimp on safety precautions (Walter, et al. 2002). In regards to dangerous jobs, and even tasks that require the repetitive motions likely to produce injuries, changes could be made to prioritize prevention of injury and maintain worker dignity and their bodily integrity. Smith-Nonini (2011:460) notes, as the injured or dead bodies of immigrant workers accumulate, it “makes it more difficult to dismiss their suffering as incidental or accidental.” In the context of the effects of transnational neoliberal policy, instigating immigration into the US, especially when unauthorized, provides surplus “renewable” labor, which limits concerns for the reproduction of labor (Smith-Nonini 2011).

Focusing on agricultural work, Benson (2008) illustrates how politics, economics and culture come to reproduce structural violence for migrant farmworkers in the US, but he also focuses on the important role of perception in recreating this structural violence. Higher status residents perceive farmworkers in a way that allows for rationalization and legitimization of patterns of exploitation. Thus, such exploitative conditions are fostered by the dialectical relationships between corporations, markets, governments, and communities. Urban immigrant workers also lack knowledge about their rights and benefits, they have an increased risk for occupational injury, and usually have adverse outcomes (Pransky, et al. 2002).
Characterization as the “other” results in stereotypes and racism that have a tangible effect on farmworkers, by limiting the “ethical responsiveness” people feel towards them, and thus naturalizing exploitation. Latino laborers, regardless of documentation status, grapple with their second-class status in popular consciousness, media accounts and in everyday exchanges and interactions, even incorporating these perceptions into their social identity (Quesada 2011). Such limits in responsiveness are clearly relevant arbitration of “deservingness” that workers must face after work-related injuries in order to access necessary services and rights.

Using qualitative and participatory research methods in Canada, Beardwood, et al. (2005) have shown how workers face a variety of trajectories after an injury. Some recover quickly and return to work with few problems, and others who were permanently disabled receive pensions as a compensation for their disability. Yet many others end up in a confusing state in which their perceptions of injury are not recognized by the compensation system. These workers face problems returning to work and difficulties with the medical system and workers’ compensation system. Thus, like the issues with “health-related deservingness” affronted by unauthorized immigrants that Willen (2012) discusses, injured workers face suspicion, stigma, and are categorized as the “undeserving injured” if their illnesses do not have a clear etiology or do not match a “template of recovery” (Beardwood, et al. 2005:31; Ewan, et al. 1991; Reid, et al. 1991; Strunin and Boden 2004b). The scientific community has at times contributed to the stigma by using compensation rates as variables in projecting the expected duration of disability or problematically promoting the notion of moral hazard (Lippel 2012; McCluskey 1998). This can have a great effect on workers who “battle” for legitimation of their experience within official systems (Jaye and Fitzgerald 2010). And yet, the system continues to be “cumbersome,
frustrating, and demeaning,” adding to workers’ already stressful experiences of injury (Strunin and Boden 2004b:338).

Much of the research on workers experience of occupational injury has been completed in international contexts, and while it reflects conditions for workers in the US, more national level research is clearly needed (Gleeson 2012b). Notwithstanding this well-established problem for public health and a growing reliance on Latino immigrant laborers, immigrant occupational health still remains understudied in more general allied health literature. A literature review of articles published between 1990 and 2005 on PubMed only found 48 articles about immigrant occupational health (Ahonen, et al. 2007; Schenker 2010). Furthermore, most social science research specifically about the workers’ compensation system has not focused on immigrant workers, even though they face many distinctive barriers and face a higher occupational injury and disease burden (Byler 2013; Howard 2010; Pearson 2013; Saunders and Nedelec 2013; Walter, et al. 2002; Widman 2006).

Despite a reemerging body of literature in anthropology, industrial medicine, sociology, and psychology that is shifting attention to the experience of workplace injury, relatively few studies have focused on immigrant workers’ experience in the US or the experience of workers post-injury (Byler 2013; Gleeson 2012). Given Latino immigrants’ burden of workplace injury and fatalities nationwide, it is imperative for researchers to study these experiences, particularly those of Latino workers (Byler 2013).

**Impacts of Workplace Injury**

Workplace injury and illness has a major impact on individuals, families, employers, and communities. Yet, with the failure of the workers’ compensation system, families and workers are left with the abdicated burden of compensation and recovery. When workers do not file a
claim or are denied one, the function of worker compensation payments as a safety incentive for employers is not fulfilled (Boden, et al. 2001; Dembe 2001). Injured workers are acutely aware of the social and financial importance of work, and researchers have investigated the role of work as a source of identity or sense of self (Saunders and Nedelec 2013; Stone 2003). In the case of injury or illness that prevents workers from returning to work, workers must uncomfortably adjust to a loss of their sense of place in the world (Stone 2003). Immigrant workplace injuries’ effect on worldviews, identity and social roles remain understudied. It is likely, considering discourses on immigration, commonly held gender roles (e.g., men as breadwinners or homemakers), and identities influenced by racialized notions of what it means to be a hard worker (Ewan, et al. 1991; Jaye and Fitzgerald 2010; Strunin and Boden 2004a; Walter, et al. 2002; Walter, et al. 2004), that injury and impairment weigh particularly heavily on Latino immigrant workers who are less likely to be insured (Dong, et al. 2007). This might be especially significant considering work is a central aspect of many immigrants’ experience, and also plays a crucial role in their health (Ahonen, et al. 2007).

**Workers’ Compensation Reform and Analysis**

In the 1980 through 1990s, many US workers’ compensation systems were in fiscal crises due to the high costs of insurance premiums. Conventional wisdom focused on moral hazard—the idea that an individual might take less care to reduce risk and cost if “they are protected (insured) against those costs” or risks—as a concern, suggesting that higher benefits paid to injured or ill workers serve as a disincentive for employees to take necessary precautions and lead to abuses of the workers’ compensation system (McCluskey 2001:55). These concerns led to reforms that targeted reducing benefits and policing fraud among claimants (McCluskey 2001). This is despite the fact that some studies have found that employer fraud is more
prevalent than claimant fraud (Supreme Court of the State of Florida. 1997). Employer fraud includes operating without required workers’ compensation insurance, underreporting payroll, and misrepresenting employees as independent contractors. A compliance audit in Florida found that from 1995 to 1996, 13.1% of employers were operating without buying such an insurance policy (Education Unit). In Rhode Island, of 5,219 fraud claims reported in 2005, 5,174 involved employers “primarily from late filing or non-compliance” (Jernigan 2008). Furthermore, the costs considered in these analysis are, like the injury and illness experienced by workers, not inevitable, and are “created and sustained by regulatory frameworks and background legal rules” obscured to the general public (McCluskey 2012:545). Most interventions and epidemiologic data rely on the concept of risk factors, and even corporate actors like insurance companies have dedicated divisions of their company to risk management. However, this often serves the purpose of avoidance and repression, an extension of what Beck (1996) has termed “manufactured uncertainty” (Smith-Nonini 2011). Studies show that financial factors continue to play a key role in the determination of occupational health interventions (van Dongen, et al. 2013), yet most analyses run by employers or insurers likely ignore the pecuniary costs to the general public and local working class communities.

For more than thirty years, media accounts have portrayed that up to 25% of workers’ compensation claims involve fraud, and they have chronicled detailed depictions of individual fraud cases (Boden, et al. 2001). This affects actual claim-filing rates, as workers decide to sacrifice potential benefits in order to avoid loss of dignity or for fear of losing their job (Boden, et al. 2001). But research on the social and economic consequences of occupational illness have been placing this issue in perspective, noting that a sizeable number of workers suffering from occupational illnesses and injuries never enter the workers’ compensation system (Boden, et al.
These media accounts have also helped push for policies restricting benefits, to the point that even when granted benefits payments account for only a fraction of the lost earnings for workers, and not all medical costs are covered (Boden, et al. 2001). Using data from 1999, researchers estimate that workers’ compensation missed between 8 billion and 23 billion in medical costs related to occupational disease, which represent a considerable cost shifting from these systems to individual injured workers and their families, and potentially to private health insurers and even taxpayers (Leigh and Robbins 2004).

Immigrant workers are more likely to face employers who contest their claims, and they face unique barriers afterwards when dealing with medical staff and insurance providers, including limited linguistic access (Gleeson 2012b). Immigration policies that heighten enforcement, such as 287(g) and Secure Communities, increase anxieties in immigrant communities regardless of individual documentation status, and “may undermine efforts to promote worker health” (Gleeson 2012b:2292). These policies have thus intensified a “fertile terrain for human and civil rights abuses” at work (Green 2011:278). Documentation status affects the legal consciousness of immigrant workers, shaping what they believe they have a right to regardless of the rights that may be officially extended to them (Gleeson 2010). This understanding further complicates issues of claims-making: even though Rhode Island workers’ compensation laws offer coverage for both documented and undocumented employees, many factors affect workers’ decision to file a claim, and that claim being recognized as “deserving” in the medico-legal system. The workers’ compensation system is thus another arena where undocumented workers are forced to make “legitimation maneuvers” (Quesada 2011). Gender bias is also relevant to this experience, leading to the dismissal of female complaints of injury by superiors and self-imposed male masking of injury, which further compromises workers’ ability
to return to work safely and allows for more rampant abuse (Curtis Breslin, et al. 2007; Saxton 2013; Walter, et al. 2004).

However, more research is needed to further investigate the reasons why workers do not file and the barriers they face during the process of deciding to file or seeking care in order to explore potential ways to mitigate burdens, as well as to know what happens after an injured worker makes a claim (Boden, et al. 2001; Gleeson 2012b).

**Biomedical and Legal Specialists and Workers’ Compensation**

Biomedicine plays a major role in the application of biopower (Foucault and Ewald 2003 [1976]; Jaye and Fitzgerald 2010). In the workers’ compensation context, biomedicine is usually situated between labor and capital (Jaye and Fitzgerald 2010). It has played an increasingly key role in the process of evaluation of injury and impairment, and has subsequently decided which workers receive benefits. This is marked by the adoption of the American Medical Association’s *Guide for the Evaluation of Permanent Impairment* by a majority of states, including Rhode Island, as the means by which to evaluate impairment without bias (Widman 2006). The guides include criteria used to determine loss of function of a body part resulting in an impairment rating or description, represented as a percentage. This rating is used to determine the amount and duration of disability payments, as well as medical treatments. This persists despite the guide’s disclaimer stating that impairment percentages are not direct measurements of work disability, and that they are not intended to be used to make such estimates (Eskay-Auerbach, et al. 2010; Widman 2006). These guides have suffered frequent critique for their inconsistency and ambiguous definitions, questionable validity and reliability, and gender bias (Eskay-Auerbach, et al. 2010). The current edition was written to respond to prior concerns about a lack of internal consistency, and how ratings fail to reflect perceived or actual loss of function (Eskay-Auerbach,
et al. 2010). In part through reliance on these guides, access to coverage hinges on provision of scientific evidence. This process can take advantage of scientific uncertainty (Lippel 2012), while simultaneously replacing workers’ own accounts for those of presumed experts.

While a focus on medical evidence relays the importance of the body as the site of where power is directly applied, this usually diminishes the body as the locus of individual truth and experience, and enforces the idea that bodies should easily display quantifiable evidence of effects (Fassin and D'Halluin 2005). Unfortunately, this is often not the case. A critical look at cost-shifting illuminates how calls for efficiency of the workers’ compensation system are more of a political strategy than a scientific goal (McCluskey 1998). Injury’s effect on an individual is difficult to quantify, and yet AMA guides serve as a cornerstone for evaluation and are being employed to produce the elusive concept of an efficient and unbiased assessment. McCluskey (1998) has utilized the archetypal but uncommon example of a pianist and a bank president each injuring a finger to receive the same percentage impairment rating, despite the banker losing no income, to illustrate the deficiencies of such use of the AMA guides (McCluskey 1998; Widman 2006). In most state systems a “schedule of benefits” would be then used to convert an impairment rating as determined by the AMA guides to a compensation rate for the “permanent partial disability,” which in Rhode Island is more commonly termed loss of function compensation or disfigurement compensation (Grabell, et al. 2015). In most states, judges factor in wage and salary information, and thus impairment ratings do not usually correspond directly to a total compensation amount. In a contrasting example, in Alabama, salary or features of employment are not considered at all, and all workers, regardless of ability to perform their job or disparity in wages, have benefit payments capped at the same amount for permanent partial disability of a specific impairment rating (Grabell and Berkes 2015). These amounts are not
calculated through economic analysis or medical studies, but are often simply politically accepted, and frequently unchanged for decades (Grabell and Berkes 2015). In Rhode Island, the maximum compensation for the loss of a specific limb or body part is outlined as half of the injured workers weekly benefit for partial incapacity, up to $180 a week, for a designated number of weeks for the relevant injury (RI Gen. Law 28-33-19). However, this award is in addition to wage loss or wage replacement weekly benefits for partially or totally incapacitated workers, and any other benefits. In Rhode Island, injured workers who sustained partial incapacity and a drop in earnings can continue to receive wage loss benefits for up to six years (Groeger, et al. 2015). After six years, the benefits are subject for reevaluation. Thus, using McCluskey’s (1998) example, in Rhode Island, if both have lost a pinky finger in a work-related injury, the pianist and the banker might receive different loss of function compensation based on their salaries, but both benefits may be capped at the same amount. Additionally, the pianist would likely also be granted weekly wage replacement benefits for partial incapacity because she is disabled from doing her job, while the banker would only be entitled to medical cost benefits. However, in Rhode Island, when workers reach maximum medical improvement (MMI)—a designation determined by a physician that I discuss further in Chapter 5—they face potential decreases in weekly benefits relating to their impairment rating (RI Gen. Law 28-33-18). These are issues that also affect the lawyers and judges who work within the medico-legal framework. Based on these policies, legal specialists are often faced with difficult decisions, including having to inform workers that their case is a lost cause because it of how impairment is evaluated and due to the connection between impairment ratings and types of compensation (Saxton 2013).

In the American context, doctors usually play the role of a gatekeeper between patients and insurance systems, and subsequently police which workers gain access to compensation systems
(Lippel 2012). In Rhode Island, while claimants have an opportunity to select a provider for their treatment, they also face the possibility of an insurance company asking for an independent medical examiner (IME) report. IMEs have shown to be more likely to make fewer diagnoses, deem fewer illnesses work-related, make fewer treatment recommendations, and assess lower levels of disability than a physician at an occupational health center. Research results indicate these differences are more likely due to divergent perspectives than variance in training or skill (Lax, et al. 2004). Physicians’ roles and dispositions clearly affect a workers’ access to coverage and their trajectory for return to work (Lippel 2012). Thus, some health professionals in such systems face “dual loyalties” with obligations to patients and also a private employer, including those working for a company-based clinic (London 2005). Furthermore, the practical moral and ethical issues health practitioners face in these medico-legal systems are usually not a focus of bioethics, where issues pertaining to terminally ill patients and other philosophical quandaries have been more common (Lurie 1994). Holmes has reverted the clinical gaze on physicians working with undocumented migrant workers to help reveal how the culture of biomedicine can prevent doctors from appreciating the structural barriers patients face (Holmes 2012; Holmes 2013). In the occupational health setting, these biases can cause drastic repercussions for patient recuperation, and yet health care workers’ decision-making and ethics are understudied by anthropologists (Castañeda 2010).

This study has produced ethnographic data that complements legal analysis and contributes to a disentangling of the structures that naturalize the pervasiveness of workplace accidents, limited access to compensation for workers, and protections for workers being described as too expensive (McCluskey 2012). I incorporated the voices of medical and legal professionals who are embedded in the workers’ compensation system, in an effort to shine light on the challenges
they face, the relation between their experiences and those of workers they seek to assist, and other unexplored facets of the system.

**Working with a Worker Organization**

Anthropologists have shown how the low-wage labor force in the US is divided by race, gender, age, immigration status, and indigeneity (Curtis Breslin, et al. 2007; Duke 2011; Holmes 2011; Quesada, et al. 2011; Walter, et al. 2004, Stuesse 2009). Additionally, workers’ perceived lack of control can help fuel the acceptance of frequent and minor injuries as “part of the job,” bringing up the issue of how workers are being “socialized to accept certain risks as reasonable parts of their everyday work” as well as ignoring concerns about working conditions (Curtis Breslin, et al. 2007:791). Yet, notwithstanding common “ethically reified division[s] of labor,” including, “racially informed perceptions of what constitutes a ‘good worker’,,” this study highlights the experiences of a group of individuals attempting to bridge these divides to educate their community, prevent further injustice, and better working conditions and treatment for all low-wage workers (Duke 2011:409).

In working with workers who have turned to community organizing after their injury, this research project was able to chronicle some workers shift from compliance to defiance and their role in educating peers about worker rights and safety, thus building on these theoretical positions. While most researchers have focused on factors that restrain vulnerable workers’ ability to demand better working conditions and achieve justice for their bodies and health, other narratives exist that show workers can be change agents demanding justice, safer environments, and protections for their health (Apostolidis 2010; Gleeson 2012). This project straddled these two narratives, documenting the challenges faced by individual workers who have actively organized in order in response to suffering injuries at work and further difficulties with a faulty
workers’ compensation system. Considering community action has played an important role in the movement for occupational health, including this aspect of Latino workers’ response to injury or illness is another strength of the study (Abrams 2001:37).
Chapter Four: Methods of Data Collection

This project utilized a variety of ethnographic methods over the course of a nine week period. Methods included participant observation, interviews, and an ethnographically grounded survey. Myself and a leader from the Injured Workers Committee conducted interviews and surveys simultaneously either at Fuerza Laboral’s office or, at a participant’s request, at their home. Initially, one of my main goals was to assure that I was introduced to all participants as voluntary researcher, and any questions committee members or organization staff had could be addressed. Due to prior contact and communication with the organization and Injured Workers Committee, I was able to begin fieldwork immediately upon arrival.

Activist Research Methodologies

When collaborating with communities facing an increasing number of challenges, the decision to engage in activist research can result in an improved relationship and trust, which are integral to producing high quality research (Pulido 2008). Activist research design reinforces an emphasis on rigor because errors do not only affect the anthropologist’s personal interests, but more crucially, unreliable data could “harm or mislead our allies” (Hale 2008:12). Collaboration also provides a “built-in test of validity” inherent in considering and discussing whether the methods “work for” and “are comprehensible” for the community members who worked to formulate the purpose of the research (Hale 2008:13). This project employed activist research design and methodologies including collaboratively developed research questions, instruments, and fieldwork. From the beginning, I explicitly positioned myself as an ally of the Injured Workers Committee and its cause, and prioritized attempting to demonstrate an understanding of
the organization’s mission and dedication to worker leadership. The survey component of this project was a major product of this activist research project. It constituted a tool for identifying potential areas for worker solidarity and action and was subsequently applied as intake form for workers coming to Fuerza Laboral to report a workplace injury for the first time.

As an engaged researcher, I made every effort to maintain worker dignity throughout the research process. Thus, it is important to note that workers who are part of the committee have been dealing not only with physical injuries and difficult changes in lifestyle, but are likely to have been victimized by the process for obtaining workers’ compensation (Beardwood, et al. 2005). Following the initial introduction, I informed the group that I intended to ask individuals to participate in interviews as part of my efforts to better understand their situation, and that all who were interested are welcome to participate, while emphasizing that my cooperation with the survey project did not require that workers chose to participate in interviews. This initial clarity for research goals contributed to more explicit acceptance or criticism of research results and a more concrete understanding of roles and distribution of results (Hale 2008).

**Survey**

The survey was used to gather aggregated information about injured workers’ experiences. It was designed through a course project for Research Methods in Applied Anthropology, in which I interviewed the organizer over the phone and audio recorded a focus group of Injured Workers Committee leaders discussing an initial draft, to arrive at a final draft. Using the information generated by the survey, this Injured Workers Committee should be able to better analyze members’ varied personal experiences and identify common threads, systematic problems, and potential foci for further action. The Injured Workers Committee will interview new workers who come forth with problems with workplace injury or illness or problems with
workers’ compensation. As mentioned above, the survey will go on to be utilized as an intake form for new workers who approach Fuerza Laboral with queries and concerns about workplace injury or disease. It will help keep track of individual’s cases, and will contribute to a growing database of problems faced by injured workers. For the present research, worker leaders filled out the survey during interviews. This survey included questions about barriers at various points in the redress process (i.e. safety instruction, informing an employer, seeking healthcare, seeking legal aid, the legal or medical process), and specific actors, agencies, or organizations that were involved. The survey is also a response to the organization’s difficulties organizing around workers’ compensation issues. Since each worker is dealt with as an individual medical case and individual legal case, it has been difficult to build a coalition around issues that affect a greater a cross-section of the community.

Interview

For worker interviews, this research project made use of convenience sampling of workers who had participated with the Injured Workers Committee (n=12). Interviews were one-on-one and semi-structured (Bernard 2006). The interviews focused on the worker’s experience leading up to and after work-related injury or illness, as well as what workers think Fuerza Laboral could organize around or what actions they could take.

I later held semi-structured interviews with the center organizer and director (n=2), as well as with key informants in medical (n=4) and legal professions (n=3) who participated in workers’ compensation cases. These professionals were identified through reputational case selection based on key contacts from the workers’ center, and then through the use of snowball sampling to identify others in similar positions (Schensul and LeCompte 2013). The criteria for referred legal professionals was a job involving interaction with Latino immigrant workers’
compensation cases. For medical professionals, I reached out to those who the center representatives are aware interact with injured Latino workers through general treatment, rehabilitation therapy, or workers’ compensation related evaluations. I sent recruitment emails or letters to doctors regardless of positive or negative reputation among worker leaders.

**Participant Observation**

Participant observation was centered on conducting the survey component of this research project, but also included participation at social events, celebrations, coalition meetings, and direct actions. These experiences allowed for informal discussion about barriers faced by injured workers and many other related issues workplace abuses. Participating in various functions allowed for more breadth in information, for example, speaking to injured workers who were did not want to participate in a formal interview, or learning about what other organizations were doing in response to problems with workplace injury and the workers’ compensation system in neighboring states like Massachusetts. Additionally, I was able to provide transportation and accompany some injured workers to visit lawyers or doctors, which allowed for a better understanding of the complexity navigating through the compensation system.

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Data Analysis

All audio files from interviews and notes from participant observation (qualitative) were transcribed in Spanish. The excerpts included in this thesis were translated into English. The transcriptions were then coded using the online qualitative data analysis software, nVivo. Coding was inductive, building patterns from identified themes to produce a greater constitutive body of results that reflects the nature of issues faced by Latino immigrant workers post-injury and its relationship to the greater context of workers’ compensation policies and procedures. Transcription and coding of notes and interviews were completed concurrently with data collection, and thus informed subsequent data collection during the fieldwork.

De-identified ethnographically grounded survey results from the first 20 surveys were analyzed using SPSS for this project in order to identify common barriers and their relationship to other factors (Bernard 2011). Common barriers were those related to the most popular responses to closed-ended survey questions. The variety of methods used allowed for triangulation of research findings.
Chapter Five: Worker Survey and Interviews Results

Sandra sat across the table at the center of the repurposed factory space that served as Fuerza Laboral’s office. She had been working at a textile manufacturer for about a year when she decided that she couldn’t take the pain and swelling she had been feeling in her left arm anymore. After leaving work to visit a doctor, she came to Fuerza for advice on what she might be able to do next. That day, she had agreed share her experience and participate in our survey. Nearing the end of our survey questions, Rogelio, an Injured Workers Committee leader, discussed the importance of workers asking employers to discuss employees’ rights and conditions for work. A little frustrated, Sandra quickly replied, “I didn’t know that then, all I knew was that I needed this job and I needed to keep working.”

This chapter summarizes the main findings of the injured worker survey, interviews, and participant observation. The subsequent chapters will summarize results from interviews with medical and legal professionals. I discuss barriers that affect vulnerable workers’ abilities to access medical care, compensation, and recovery after a work-related injury. I later highlight some of the challenges faced by medical and legal personnel in treating and representing Latino immigrants as part of the workers’ compensation system, as well as their ethical considerations during decision making (Castañeda 2010).

Sandra’s frustration with having been unaware of worker’s compensation insurance and benefits, and the necessity of pushing her physical pain aside to keep working, was shared by many other participants, even though they may have had very different injuries in other industries. Aside from these similarities, all worker participants made the decision to eventually
file a compensation claim and to reach out to Fuerza Laboral for assistance or orientation.

Entering and enduring this system was rarely a simple endeavor. In fact, the process is better characterized by what a sign on the entrance to the worker’s compensation court’s office terms an “odyssey” (Figure 1).

This chapter presents data on the challenges Latino immigrant workers face when injured on the job, and how their experiences relate to the medico-legal policies governing workers’ compensation. The data is reported in eight sections, based on themes that emerged in the interviews: general information about the workers, work environment, injury and reactions from supervisors or employers, accessing medical care and legal aid, problems while receiving compensation, medical personnel’s perspectives, and legal personnel’s perspectives. All of the names of participants in this chapter and the subsequent chapters are pseudonyms, unless stated otherwise.

**General Information**

Eleven of the twenty workers surveyed were male and nine were female, with ages ranging from 21 to 62 years old. The mean age was 41.9 years old, and the distribution is slightly negatively skewed with a median of 43.5 years old, and mode of 46 years old (Figure 2). This
indicates that despite the participation of workers younger than the average age (8 workers), and two younger than 30 years old, the majority of workers interviewed (12 workers) were older than 41.9 years old. All but two interviews with workers were conducted in Spanish. Interviewers were all fluent Spanish speakers.

All injured workers were immigrants from Latin America, and though country of origin was not formally documented as part of the survey, eleven participants noted their home country during the interview and survey. Participants were from the following countries: Guatemala (five workers), Columbia (three workers), the Dominican Republic (one worker), Argentina (one worker), and Mexico (one worker). Because not all workers were paid by time (for instance, a participant who worked as a truck driver was paid by trip), only thirteen participants provided their hourly wage information at time of their accident, which ranged between six dollars an hour to 17 dollars an hour. The average hourly rate of $9.73 for this sample is not considered a particularly useful measure because of the wide diversity of industries represented in the survey.
Additionally, higher wages themselves do not indicate lack of exploitation. For example, for one tree-servicing participant who had been employed by the same company for twelve years at the time of his accident, his 14 dollars an hour pay rate was considerably less than the starting rate of 25 dollars an hour his documented Anglo-American co-workers received. Participants worked at 16 different companies, and in eight different industries: manufacturing (five participants), warehousing or freight (four participants), restaurant services (three participants), demolition recycling (three participants), food processing (two participants), cleaning (one participant), construction (one participant), and tree servicing (one participant). Participants had worked an average of 3.03 years at the company where they sustained an injury, with a minimum of one day to a maximum of twelve years, a median of two years, and with modes at one month, fourth months, and two years or 24 months (Figure 3). Half (ten) of participants were injured within two years of working at the company, with eight participants injured during their first year on the job. However, it is important to note that the injury trajectory discussed by participants who had been working with the same employer for many years in our survey was at times not the first injury they had suffered, but was either the first they filed a claim for, reported, or the first that was contested. One participant noted having been injured on the job twice before knowing he had a right to worker’s compensation and filing a claim for his third and most serious accident.

Table 2. Participant Working in Eight Industries

<table>
<thead>
<tr>
<th>Industry</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturing</td>
<td>5</td>
</tr>
<tr>
<td>Warehousing or freight</td>
<td>4</td>
</tr>
<tr>
<td>Restaurant services</td>
<td>3</td>
</tr>
<tr>
<td>Demolition recycling</td>
<td>3</td>
</tr>
<tr>
<td>Food processing</td>
<td>2</td>
</tr>
<tr>
<td>Cleaning</td>
<td>1</td>
</tr>
<tr>
<td>Construction</td>
<td>1</td>
</tr>
<tr>
<td>Tree servicing</td>
<td>1</td>
</tr>
</tbody>
</table>
Figure 3. Histogram of months working at the same employer at the time of participant's work-related injury or illness (interval width= 6 months)

Work Environment

Of the 20 participants surveyed, including the 12 that were interviewed, 16 reported not receiving any safety training, and one additional participant reported the training they received to be inadequate (Table 2). Lázaro, a participant who had worked in demolition, noted that the lack of training was pervasive at his place of work, “almost everyone working with heavy machinery did not have licenses to drive or operate them, there was very little training…contributing to daily accidents.” Graciela discussed that while working in a warehouse, “We never had any kind of safety training, safety meetings, or OSHA trainings, or training on how not to hurt ourselves, or how to lift heavy loads, or how to handle the pallets.” Her co-worker, Marta, was asked to sign paperwork verifying she had taken an Occupational Safety and Health Administration (OSHA) course she was never offered and did not attend. Another participant, Lisa was injured when left unsupervised during her training period for a job as a machine operator at a textiles manufacturer.
When I had the accident, she [supervisor/trainer] went to the bathroom, it was like eight in the morning, and she said, ‘I’ll be right back.’ A lot of time passed, I could easily say more than twenty minutes...the machine stopped because she had left it running. I didn’t take action, I didn’t do anything, I told myself I’m going to wait because she’s in the bathroom...[later] realizing she was still not coming back, well then, I said, since I’ve done it before, I’ll do it.

Seventeen participants were not provided with safety equipment, and for some the cost of subpar equipment was deducted from their pay. Jorge, also working in demolition and recycling, explains,

I needed more protection and information. Gloves ripped open, and you would ask and ask [for replacements], and they say, ‘There’s none.’ Then when OSHA would come to see how they were working, then that morning they’d have someone go around and give out gloves and safety goggles, ‘Take these because those don’t work.

Alvaro was hired to work for a cleaning company, “cleaning offices, and we would clean floors, bathrooms, cafeterias, a cleaning that most offices require every day.” After almost three years of work without gaining more hours or more favorable schedule, he was asked by the owner of the company to take a special job. The next week they went to a recently vacated office building in Massachusetts, and he was surprised to learn, “We had to take out all the furniture. So we started doing that work, and they never gave us a safety support belt, or gloves, or boots, or helmets, or anything, just as we were, and moving them was almost impossible... This is no longer cleaning, this is moving.”

Table 3. Workplace Environment Survey Responses (n=20)

<table>
<thead>
<tr>
<th>Problem or Situation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were not provided any information about workers' compensation</td>
<td>18</td>
</tr>
<tr>
<td>Were not provided safety equipment</td>
<td>17</td>
</tr>
<tr>
<td>Received no safety training</td>
<td>16</td>
</tr>
<tr>
<td>Knew of others who were injured at same company</td>
<td>14</td>
</tr>
<tr>
<td>Pace of work was too fast to the point it prevented you from taking precautions</td>
<td>12</td>
</tr>
<tr>
<td>No required Department of Labor Employee Rights posters in workplace</td>
<td>11</td>
</tr>
<tr>
<td>General unsafe environment</td>
<td>4</td>
</tr>
<tr>
<td>Threatened with being reported to immigration authorities before accident</td>
<td>1</td>
</tr>
<tr>
<td>Received another type of threat before the accident</td>
<td>1</td>
</tr>
</tbody>
</table>
At 62 years old, Alvaro was the oldest participant we interviewed, and after weeks of moving furniture, he remembers even his young co-worker being surprised at the conditions, telling him, “I work with a moving company on the weekends, but they give us belts, everything, and we don’t have to use this much force, they’re abusing us here.”

Participants were overwhelmingly not informed about workers’ compensation by their employers before an injury, with 18 of 20 injured workers surveyed reporting this situation (Table 2). The remaining two workers were informed about worker’s compensation by their employers after their injuries. Education about workers’ rights in a central part of Fuerza Laboral’s goals, and these results both highlight the importance of these initiatives, and the pervasiveness of employers shrugging such responsibilities, at times directly misinforming workers. Even simplistic requirements like displaying the Department of Labor’s “Employee Rights” information in the workplace were ignored by the employers of eleven participants. As, Jorge discusses, uncertainty about legal protections is heightened for undocumented workers,

We don’t have papers, we are scared, and we don’t know if laws for the immigrant exist in this country. Everyone who comes to this country isn’t sure if the law protects them. I didn’t know.

Jorge and Sandra’s experiences demonstrate how a lack of information about which protections exist and which apply to undocumented workers can lead injured workers to delay filing claims, seeking medical care, and legal representation. Not knowing about other options, Sandra worked through six months of pain in her hand and arm before seeing a doctor. Jorge notified his supervisor of his injury on the day it happened, the 24th of the month, but “they didn’t send me to a hospital until the 27th… it’s two days I was working with my hand…. But I couldn’t stand the pain in my hand, working with only one hand, because they usually both work together, but with just one it’s very difficult.”
Four participants characterized their workplace as generally unsafe. Magdalena describes how a few careless practices made the stuffed animal factory where she worked dangerous for employees.

There was nowhere to walk, the aisles were very narrow, and a large vinyl sheet is what covered the floor so that the stuffed animals wouldn’t be directly on the floor. There was no safety. More than one time, not me, but another employee…she twisted her ankle, she didn’t break but she stepped on a pallet, because they left everything thrown around. There was no safety for employees there. More than one time I almost fell and others too.

Accordingly, fourteen participants knew of other employees who had sustained injuries at the same company. Participants also reported having warned their supervisors previously about the hazards they were concerned about, usually with little concern paid or no changes made. Marta warned her boss that the snowy and rainy conditions meant that the loading platforms were wet and slippery, but he responded saying that it didn’t matter and to keep working. Henry had similarly warned his supervisors about the dangers of leaking potato washing machinery that eventually caused him to slip and fracture his ankle, “The water from that machine passed into the storage area where we worked, and I always told my boss—he was North American—that he had to watch that because there was no drain near there.” Lisa and her supervisor had also requested repairs for the machine she was being trained to operate to no avail, “I asked about this a lot, why was the machine stopping so much? …Our work never showed. And [my supervisor] told me, yes, this machine is bad, I always tell them and they don’t listen.” Additionally, most workers noted that their jobs were very fast paced, to the point that it prevented them from taking safety precautions.

Only two participants received threats from employers before their injury. One was threatened with being reported to ICE so that they would be deported, while another received another type of threat. However, other workers reported that rumors about workers being fired
where common, as one participant explained, “There were rumors that they were going to fire people, but we didn’t know who it was.” Another described how rumors sometimes circulated about undocumented workers, “The teacher that taught us to sew, she sometimes went to meetings with the bosses … and rumors would get out that they were going to fire the undocumented employees, but they were rumors.” Additionally, workers discussed having difficult supervisors. For example, Lázaro’s group leader was regularly drunk, called everyone “stupid” constantly, and regularly disregarded employees. Participants also faced discrimination in pay and treatment. Eliana was paid $240 for a 40-hour workweek, meaning at six dollars an hour she was paid at below minimum wage. In tree servicing, Edgar noted that Latinos performed the most dangerous tasks involving cutting branches while up in the tree, and better paid Anglo-American co-workers would work moving items into the chipper while on the ground. Furthermore, as mentioned previously, in demolition and industrial recycling, Anglo-American workers’ requests for functional protective equipment were usually honored while Latino workers were left to work with worn and broken equipment. Female participants also faced additional challenges at work. Two participants discussed that in addition to other labor rights being violated, sexual assault was common at their workplace, and another reported not having been offered maternity leave, missing work only the day she gave birth.

These findings underline the contexts that contribute to difficult and confrontational work environments. Our survey explicitly focused on documenting the types of abuses and challenges that injured workers faced, and in an attempt to identify common problems, so perhaps this is not surprising. However, some participants reported a pleasant or neutral work environment, where they were sometimes even favored by their supervisors. One participant was quickly promoted to a mechanic position ahead of other workers who had been at the company longer, and another
noted that his previous employers feared losing him to a new branch of the restaurant opening closer to home, telling him, “You’re a good cook, they’re going to offer you money to stay there.” However, generally even affable relationships with employers tended to become more complicated after injury.

**The Injury and Reactions from Supervisors**

Participants related injuries at the knee (four workers), back (four workers), leg (three workers), hand (three workers), foot (three workers), arm (three workers), shoulder (three workers), fingers (two workers), bladder (one worker), head (one worker), and ankle (one worker). As discussed in the previous section, some injuries were directly related to dangerous conditions, like slippery floors and faulty machinery, or lack of training or equipment. Others had true accidents that perhaps were not as directly avoidable but which should still be covered by their employers’ workers’ compensation insurance policy because they were sustained while performing work-related tasks. The time directly following an injury also marks when important steps would be taken for the system to function well. Employers would need to report the injury and help the injured worker get medical attention. However, for some survey participants not only reporting, but even sustaining an injury or having had an accident was enough to provoke aggressive reactions from employers including multiple forms of retaliation and evasion.

Like other participants, Eliana had previously alerted the owner of the restaurant she worked at in Cranston, Rhode Island, about the broken glass in the boxes of soda and beer deliveries and her concerns about someone getting hurt. Despite these efforts, she herself fell victim to her supervisor’s relative negligence. I started to put them away, but I didn’t feel anything broken, and then, ‘Oh my God!’ Something happened to me...Then came the owner, because he was there. He says, ‘What happened? Oh no, what did you do to yourself? You’re going home.’ They wanted to send me home. An employee from a store down the street was there and said, “You are
not going to send her off like that because this is a serious condition. A coworker came with a bottle of rubbing alcohol and cotton and she said to me, ‘We’ll take care of this.’ But how could they take care of it, I couldn’t feel anything, I looked and saw that a small white bone was out on top, I didn’t even know what to do. And, of course, I drifted off little by little, I lost consciousness, until we got to the hospital. I felt the ambulance moving and from then on I don’t know.

Table 4. Survey Responses about Responses to Injury (n=20)

<table>
<thead>
<tr>
<th>Problem or Situation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were not provided first aid after accident</td>
<td>13</td>
</tr>
<tr>
<td>Participants fired after injury</td>
<td>7</td>
</tr>
<tr>
<td>Supervisor was aggressive in response to report/accident</td>
<td>7</td>
</tr>
<tr>
<td>Supervisor did not file a report regarding the accident</td>
<td>7</td>
</tr>
<tr>
<td>Participants who have ignored injury or problem due to fear of the consequences</td>
<td>7</td>
</tr>
<tr>
<td>Participants fired while on &quot;light duty&quot;</td>
<td>3</td>
</tr>
<tr>
<td>Participants fired after returning from receiving workers compensation benefits</td>
<td>3</td>
</tr>
<tr>
<td>Supervisor threatened to fire them after accident</td>
<td>2</td>
</tr>
<tr>
<td>Pressured to go to company clinic</td>
<td>2</td>
</tr>
<tr>
<td>Supervisor threatened with being reported to ICE after accident</td>
<td>2</td>
</tr>
<tr>
<td>Pressured to say accident did not happen at work</td>
<td>2</td>
</tr>
</tbody>
</table>

Eliana had seriously lacerated her arm on a broken glass bottle. Had she been able to take her employer’s advice and “go home,” her life would have been in jeopardy. Due to a bystander’s advocacy, and ironically, the undeniable severity of her injury, she was called an ambulance and received timely medical care. Her trying experience demonstrates the importance of supervisors’ and employers’ role in assuring injured employees with receiving appropriate medical care, but also the frantic denial and unscrupulous behavior that could lead to worse outcomes. Jorge was helping a co-worker lift a large rock from machinery in which it was caught, and when the co-worker let go, the rock fell on his left hand. “In that moment my vision darkened, I fell, and hit my face ... Eight minutes later, I came to and got down from the machine … I felt like the earth was spinning, sat down, and did not feel well.” Jorge told another co-worker what had happened, and was taken to see the cousin of the boss.

He was already there, and he left me sitting there with him. I think in an hour the boss came as asked me, ‘Are you okay? You’re going to the hospital?’ And I said, ‘Yes, okay.’ What he did is take me on a motorcycle to the office. Since there’s ice there, she
put it here, and told me that when it warmed up to put it on my face, I didn’t work the
next two hours… I went home but I couldn’t sleep almost all night. I wanted to go to the
hospital on Sunday but I thought if I go, I’d get into problems. How will I pay the bills? I
had nothing. Monday I went to work, and I was complaining in the morning, and at noon
I went with Fernando [a co-worker] to speak to the boss and what did they do? Four
aspirins, ‘Take two and then two when you go to sleep.’ I took two and they didn’t do
anything.

The next morning, Jorge ask for help again, this time speaking in charge of the trucks at the
company, and he agreed to help him contact administrators.

He called and in a bit a car arrived. A tall American, blonde hair, asked, ‘You’re feeling
bad?’ ‘Yes, I was doing bad that day but they told me I wasn’t bad. Look at how my hand
is? And my head.’ He replied, “Take this paper, go to the hospital on Branch [Avenue],
Concentra.’ He had me sent me to the hospital…I saw the boss and he saw me, and said,
‘You’re going to the hospital but you’re not going to say it was at the company, you’re
going to say it was at your house.’

Jorge’s employees provided unsatisfactory “first-aid” for an injury of that magnitude, had
him wait hours, and expected him return to work before helping him seek medical care. Even at
that point, he was not informed about worker’s compensation, and instead instructed to lie about
the nature of his injury so that the company could avoid filing a report and alerting their insurer.
This prolonged the agonizing pain that Jorge experienced as a result of this injury. Lázaro,
another participant working at the same company, had a similar experience following an injury.
He had not been wearing boots resistant to perforation, and the nail passed through the shoe into
his foot. After having a co-worker pull it out, he reported the injury to his supervisor who told
him to sit down. Another supervisor later told him to keep sitting and wait to see if he felt better,
and in that case, return to work that same day. Lázaro, was incredulous at the suggestion and
insisted on going to a clinic. Like, Jorge, he was instructed to say he was injured at home and
promised he would be reimbursed for the costs. Instructing employees to lie about the nature of
their injury, and hesitating to provide health care were only some way employers attempt to shirk
their responsibilities.
Withholding information about workers’ compensation, as discussed in the previous section, was also common. For example, Sandra reported her pain to her supervisor, who responded with medical advice, “You should get an x-ray,” but no information about support or workers’ compensation policies. It is conceivable that her supervisor might have been ignorant of workers’ compensation procedures as well, but the results were the same for Sandra: confusion and delay in establishing her claim. Informing supervisors and other employees about procedures is important because protocols at a given company can be fairly complex. Hector was pushing a pallet of processed vegetables that was not accessible with a forklift, and fell backwards. Not knowing about workers’ compensation, he thought it would be better to go home than visit the hospital. However, he was worried about the waiver he was asked to sign in English, which he later learned stated he had been offered to be take to care but had refused. Had these documents been provided in Spanish or had he known about the workers’ compensation system, this situation might not have been seen as threatening. Finally, two other participants had to provide their own transportation to obtain medical care due to their supervisors being absent. Lisa drove herself home after a hand injury, and Jasmin had her daughter, who did not have a driver’s license, take her to the hospital after she injured her left knee.

Participants also faced antagonistic employers while away from work on compensation leave or at the hospital. Eric, who had fallen and broken his foot while working to fix a jammed machine, went to the hospital and had surgery the following day. The day after the surgery, he received a call from his employer’s Human Resources department letting him know that if he didn’t return to work the next day he would be fired. He was alarmed by their response, as they knew he had been injured and had not even asked about his progress. Walter, working in commercial siding and waterproofing, was also pressured to return to work as soon as possible.
After falling from a lift, he ripped the tendons and muscles in his arm. He told his supervisor who replied, “That’s nothing,” and later went to the management office to report the accident. While out on workers’ compensation, he documented how his employers would persistently e-mail him asking if he was ready to come back to work, and pressuring him to come back as soon as possible. Walter ended up asking his doctor to give him permission to return to work even though he was not ready.

Some workers faced hostility before filing a claim or reporting an injury. Jasmin decided not to file a claim or report her injury at first, but instead use her own insurance to cover the cost of her injuries and resigned. A few weeks later she visited her employer to ask for a letter so that she could apply for unemployment benefits while she found a new job as “she had no other way to support [herself] economically.” In her words, “They didn’t want to give me a paper that said I wasn’t working, even not including that I had fallen, that I had been hurt.” It took them weeks to get back to her, and when they finally provided a letter, it stated she had been fired and was an irresponsible worker, and that they disapproved of her attitude and conduct. Jasmin was very offended by the letter, as she had worked with several employers since moving to the United States who had given her glowing references, and considered herself a dedicated and hardworking employee. It was only then that Jasmin decided to file a workers’ compensation claim. However, her employers continued to leverage their influence to weaken her case.

The day before court, my lawyer called me to say he had just heard that the company had submitted a witness testimony signed by one person that said [I] was playing around. That [I] was jumping from chair to chair, and that [I] jumped off and said, “Superman! Spiderman!” And so I told him, wow, what an incredible story, because I am fifty-two years old, and I recently had a hyperparathyroidism surgery. How could I go around jumping from chair to chair?

Jasmin had previously contacted the co-worker who had provided the statement, and asked her to serve as a witness on her behalf. Jasmin reached out to her again, and she explained that, ‘they
said they were going to give me more hours, and they were going to fire me if I didn’t sign.” She and one other worker both experienced being blindsided by co-workers who were bribed or coerced to serve as witnesses against them, and the frustration at losing trust in friends and colleagues heightened the difficulty of dealing with a serious injury. Eliana’s case included another example of fraudulent employer behavior. Her employer and her employer’s legal team convinced her coworkers, who were there the day of the accident, to testify she did not work at the restaurant, despite the fact that she was picked up from the site by ambulance. Eliana was more vulnerable to this attempted evasion of responsibility because she was paid in cash.

These experiences highlight another way employers can exert unduly influence on not just injured workers, but also co-workers, and how their power is heightened at times of high unemployment or an economic recession. The fear of being fired has a huge influence on workers in precarious employment, and even workers who considered themselves fairly established at a company.

This uneven influence continued to have an effect when employees return to work. Returning to work meant lifting heavy objects for Walter and having lost half the strength in his arm, he had a difficult time. However, despite the enthusiasm his supervisors had contacted him about returning to work, he was eventually fired for “lacking experience,” despite having worked in the industry for many years. Luckily, Eliana’s case was decided in her favor, and her lawyer was able to provide enough evidence to rebuff those testimonies. After eight months out of work, Eric was contacted by his employers and offered a light-duty position where he be sitting comfortably, and brought materials to work with at a table, and thus avoid heavy lifting. His lawyer anxiously urged him to take the job, “You have to work or else this will be a problem,” so he went to be evaluated by a doctor was approved for light duty work. When he arrived at work,
he saw a beaten up and bare chair, and no one was there to help him carry materials, so he was forced to lift heavy boxes, sweep, and take out the garbage. After the first week, his back began to hurt so much he could not sleep. He resolved to ask a young woman from Human Resources to interpret for him, and told a group of Human Resources representatives that this is not what he had agree to. At that point, a higher-level administrator started yelling at him and telling him “What do you think you’re doing here? You have no right to be here.” He left and returned later that day, only to be faced by a similar barrage of insults by the same high-level employee—“What do you want a bed and to be spoon-fed? You’re worthless.” He was so angry and aggressive that he had to be restrained by two other staff members. After this incident he was provided a new chair and an assistant, but these accommodations came with now ongoing daily harassment by the same aggressive supervisor. The verbal abuse grew to affect him greatly, leading to a diagnosis of depression, and his doctor granting him a month of leave. When he returned, he was promptly fired.

Sandra also faced persistent harassment after returning to work after seeking medical care, her supervisor was now breathing down her neck the entire workday. Lázaro, Jorge, and two more coworkers who were injured at work, were all fired with no reason given. Lázaro had not been injured in more than a year, but had taken Jorge to see a doctor, and believes he was fired for helping his friend. Another participant injured his ankle and was given five days, and then one more week off by his doctor. When he returned to work, he was promptly fired, and his employers cited the accusation that he had stolen some shrimp as the reason. The “shrimp” in question poignantly highlights the how the smallest, most insignificant reasons can be used to rationalize employee dismissal. Carlos, who we spoke to while still hospitalized, voiced related anxieties.
I fear being fired from my job quickly even if I was accepted back, because I wouldn’t be preforming at the same rate and pace as before. Then I would be left without a job, without compensation, because doctors would say I was fine and could do, but I would have no way to support myself.

Carlos understood his value as an employee predicated on the speed and efficiency in which he was able to get tasks done. His supervisor, in trying to convince him to originally take the job, told him, “Come, I want you to help me, because over there there’s only Americans and that doesn’t work.” His fears also highlight the compromised nature of “light duty” work, which attracts much attention as an ideal, but is rarely a reliable reality for workers. Unfortunately, the seven dismissals after returning to work from an injury documented in this research project, and the experiences of workers fired on light duty, illustrate that Carlos’ anxieties are not unfounded.

Additional methods of retaliation affect undocumented workers. Edgar suspects that he and four other injured, undocumented co-workers who were detained by immigration the same week were reported to authorities by their employer. And while Immigration and Customs Enforcement (ICE) reports most of their worksite initiatives are focused on identifying signs of exploitation and smuggling, the circumstances in this case do not feel coincidental to those affected (Immigration and Customs Enforcement). While detained, Edgar endured a nine-month long legal battle, but was not deported, and was eventually granted work-permit. After returning home, he was visited by his supervisor, who assumed he had simply crossed the border again and would be interested in work. Edgar confronted his boss, asking, “Why would I want to work for you when you have caused me and my family so much pain?” And while his employer could have denied these allegations outright, he simply claimed that the insurance company, but not the employer, had called immigration.

And yet, a few participants reported supervisors supporting them post-injury. One had a manager file a report and direct her to worker’s compensation, and another’s supervisor filed the
report and drove her to the hospital. However, upon returning to work, the latter participant realized that her boss had been fired. She worried that it had been because of his response to the accident—“When they were taking down my report, I saw the pressure on him. He was doing the right thing.” This example demonstrates how not only lower-level employees are subject to fear of retaliation for following the correct procedures after an injury.

An encouraging response to the claims being made by some participants in this survey was an increase in safety training or provision of equipment. Even while individuals who filed the claim were retaliated against or fired, some who either continue working at the company, or maintained contact with former workers, noted that more equipment, like masks with ventilators were not being distributed to workers, or safety trainings were now offered and required.

So then came the insurance, and other ladies, to a meeting. And they were saying, ‘Don’t be scared, if someone gets hurt, and if the company doesn’t want to take responsibility, call the police, the police will call you an ambulance, even if the boss doesn’t believe it. But they started doing this after me, right now they are distributing gloves, and masks with filters on both sides…and at that company there’s a lot of dust. That’s why I would not go back there, because there’s so much dust, and the walls of a house have so many chemicals, and those chemicals are bad for people’s health. Like what happened to Ernie. There you swallow it down, and that’s why he’s sick. They didn’t give you a mask at that time. At least now they give them masks.

However, “enforcement” of protocols can exacerbate inequities between Latino immigrant workers and other employees. For example, Edgar noted that while more safety trainings were being offered after a string of several injuries and claims, they were only held in Spanish. He had also recently also been asked to attend a meeting where he had been shown a photograph of himself using dangerous techniques to complete his job, which he assumed was taken by insurance company representatives. He was asked to sign a document stating that he would discontinue taking these risks at work. However, the document was again only presented in English. These efforts did not account for how his supervisors on the ground would routinely
ask him to complete such dangerous tasks. Such enforcement could be used to penalize workers like Edgar who are asked to take risks at work, fear dismissal if they do not comply, and are denied meaningful access to safety training, and would not address the expectations of the company administrators, and other factors that might push supervisors to make dangerous demands of employees.

Another theme emerging from surveys and interviews was workers’ desire to avoid conflict, and filing a claim altogether when possible. Some workers accepted employer’s verbal promise to provide them with a weekly stipend before growing concerns about the severity of the sequela of their injury propelled them file an official claim. Jasmin never planned on filing a claim because they felt it would be “unfair” to the company they had worked at for a short time, “I didn’t think of making a claim because I had been working there just a few months,” she said. Another participant discussed how she did not want to enter a lawsuit, but instead, “I don’t want to file a suit… I want for them to be responsible, for them to pay my time lost and the [medical] bills.” Participants also echoed each other’s desire to work, beginning with employment as an impetus of migration, “I came here to work,” and a sustaining part of life, “One can’t live without work,” and in their actions of rushing doctor’s to give them permission to return to work, or even putting aside pain for long periods of time in order to keep working. This is significant as workers are often depicted as having ulterior motives to filing claims; including the perception that this is an opportunity for them to leave their jobs, and make money in the case of a settlement.

**Accessing Medical Care**

After an injury, and notifying a supervisor, the next step in a typical trajectory for an injured worker is accessing medical care. However, difficulties in obtaining care and
communicating with providers persist beyond accessing medical care for the initial injury. The system itself, involving seeing a treating physician, specialists, insurance-ordered Independent Medical Evaluations and court-ordered Impartial Medical Evaluations (IMEs), can be overwhelming, and one participant exasperatedly explained, “They have me tangled-up with all the doctors. A doctor over here, a doctor over there, now they called me about making another appointment for another a diagnostic test.” Experiences with medical professionals and facilities varied widely as participants attended 22 different facilities. Seven participants went to Rhode Island Hospital, either as a patient in the Emergency Room or for follow-up treatment. Six participants went to Concentra Urgent Care Center. Three participants were taken or referred to Concentra by their employer.

Table 5. Experiences at Medical Facilities

<table>
<thead>
<tr>
<th>22 Medical Facilities Visited</th>
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<tbody>
<tr>
<td>Participants not provided with an interpreter</td>
<td>7</td>
</tr>
<tr>
<td>Returned for follow-up at same health facility as first visit</td>
<td>7</td>
</tr>
<tr>
<td>Participants were treated disrespectfully</td>
<td>5</td>
</tr>
<tr>
<td>Participants received inadequate medical treatment</td>
<td>4</td>
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The survey focused on three general groupings of challenges: language access, quality of attention and interventions received, and how patients chose their care providers. The latter’s importance relates to the Workers’ Compensation Law in Rhode Island, which allows injured workers to chose their own physician after their initial visit to the emergency room or a doctor suggested by an employer. This means that second visit to a doctor is a worker’s choice for “first medical care provider,” and who they chose can be an important factor in their case (Educational Unit). Seven participants in our survey returned to the same facility they initially visited, even though three described their experience at the health facility as negative or lacking in some
manner. Five participants were treated disrespectfully at a health facility, and four considered their medical treatment inadequate. In fact, these challenges are in many ways interconnected, as a lack of quality interpretation can lead to compromised medical evaluation, treatment, and subsequent frustrations. Carlos’ experience in the Emergency Room was one of the most striking. He arrived at the hospital after falling down the stairs while closing up the restaurant, sustaining acute injury to his knees.

I thought they were going to leave me there [hospital] for five days or a week. They had me wait around two hours and they didn’t see me, and I came in on a stretcher, on an ambulance. The doctor came in, and he said, ‘Can you stretch out your foot?’ ‘No,’ I said. He stretched them out, and I felt that it hurt a good deal, but he stretched them out. Then he said, ‘Now bring them in.’ ‘I can’t, and the other one either,’ I said. And from when he did that they stayed that way. ‘Well, we’ll do x-rays. Does it hurt a lot?’ They gave me Tylenol, but that didn’t do anything. Then they did the x-rays, and he said, ‘It’s that the liquid got out, in five days you’ll be fine.’ I don’t think so, I thought, but sometimes one believes and other times not. And he came and bandaged me up, and they put me in a wheelchair, and they took me out to the curb. They left me in the lobby, and, ‘Call someone to pick you up.’ … At one in the morning they left me outside the hospital. I don’t understand why they left me out there. I don’t have insurance. Maybe that’s why they left me outside. My legs felt like they were falling off.

Rhode Island Hospital’s Emergency Center is one of the busiest in the nation, seeing 110,000 people a year (Rhode Island Hospital). This may contribute to Carlos’ long wait, and his physician’s hurried demeanor, but still does not explain the misdiagnosis of the severity of his injury. Carlos called his sister to pick him up, but everything from getting into the car onward proved to be incredibly difficult.

Because I couldn’t stand, [my sister] and a man who was there, and together they carried me in on my side, because the car was a four-door, laying down on the seat. The problem was getting home, because I live on the third floor, and I couldn’t even lift my leg. I went to the extreme measure of asking my sister just to leave me there and bring me a blanket, because I couldn’t get up. … She called her husband…he grabbed me and carried me upstairs. Oh my goodness! Now what do it do? The hospital only gave me two small cold packs, which lasted half an hour…The next day, I stayed there, I didn’t even want to go to the bathroom because I couldn’t move, and my sister told me, ‘I’m going to leave you food,’ and gave me the phone. I was already thinking I have to go to dialysis on Tuesday…And well since they said I’d be better in five days, one day I tried walking
around with just a cane, and I fell in my house, and that was the worst because everything that I had already healed—now that hurt.

When the insurance finally got in touch, Carlos was able to return to the hospital and get braces, but was then was told by the insurance representative to visit Concentra Urgent Care Center from now on. There he was referred an MRI and, based on the results, his doctor scheduled him for bilateral surgery. Carlos’ trajectory vividly exposes various shortcomings in his initial treatment and indications, and there is no doubt that the initial care he received was inadequate. Medical professionals could have considered his medical history (i.e. renal disease) and sought an understanding of his resources and social condition (i.e. having only one family member in the country) in order to reduce the danger of injuring himself doubly. Participants’ misgivings about their symptoms being downplayed are indicative of the suspicion that results from physicians serving as gatekeepers and arbiters in a medicolegal system and the contested nature of chronic pain syndromes in general (Good et al. 1992). Carlos’ fears of being treated differently because he was uninsured also highlight how injured workers without health insurance are denied access to care while their compensation case is not yet established or being contested.

While Jasmin’s case was contested from the beginning, having private health insurance allowed her to seek care without fear of being unable to pay for treatment, instead of waiting for a call and permission from an insurance carrier. She was able to secure treatment, if not yet justice. However, Jasmin’s experience at the hospital also presents an interesting example of the dimensions of importance of medical interpretation. She is one of seven participants who were not provided an interpreter at a health facility. Jasmin’s 19-year-old daughter drove her to Memorial Hospital after her injury, and later also interpreted for Jasmin and the doctor. It is well established that untrained interpreters are at a greater risk of committing errors, omissions, and
truncations that could be of consequence in medical diagnosis and treatment (Bernstein, et al. 2002; Jacobs, et al. 2004; Karliner, et al. 2007; Ku and Flores 2005; Monroe and Shirazian 2004; Morales, et al. 2006). However, having no third-party interpreter also multiplied the complexity of her workers’ compensation case in court. The judge presiding over her case found that the account Jasmin gave to doctors the day of her accident could not be used to verify her account in court because her own daughter had served as an interpreter, and thus could be considered biased towards her mother. Thus, adequate and reliable language access takes on increased significance within a medico-legal system.

When injured workers visit a health facility after filing a claim, they are identified as workers’ compensation patients based on their insurance carrier. In this way they are subject to discrimination based on popularly held biases about workers’ compensation claimants (Boden, et al. 2001). Sandra visited two different health facilities for the injury to her left arm, and she described feeling humiliated when seeking care as the greatest challenge she faced in the workers’ compensation system.

The most difficult part is not having health insurance and using the one provided through workers’ compensation, it’s very humiliating. They humiliate you too much. It feels like one is begging, you’re asking for something that may by law practically correspond to you, but they make you feel like you were begging… I feel that when they say, “Oh, workers’ compensation,” like they make you feel like it’s your fault, that it was you, like you are a bad person…For example, the one that was did my physical therapy would tell me in English, ‘All the time, everyday, I have to be seeing you.’ One time she even made me cry while there, and then she was say, “Oh, no it’s okay,’ you know. So I told her, ‘If it was up to me I would go home now and find another doctor, that would be no issue for me.

For other participants, disrespectful treatment was intertwined with denial of language access, like in the case of being asked to bring their own interpreter to a medical visit, “There they also told me, bring your own interpreter because the doctor doesn’t speak Spanish.”
Through analysis of interviews, three other areas of tension arose that contributed to dissatisfaction with medical encounters: discrepancies between patients’ experiences and the results of a physician’s evaluation, counterintuitive interactions with independent or impartial medical examiners, and issues with facilities requiring preauthorization from insurance carriers.

It is not uncommon for patients to disagree on elements of their experience and efficacy of treatment with their physician, but in a medicolegal system like workers’ compensation, these discrepancies can be further complicated and their consequences amplified. Eliana explained confusion upon being discharged from treatment for her injury.

Yes, I went [to the doctor], two times [after the surgery] … and, ‘You’re all better now,’ he tells me. I am not well I have this here and what is this? What he said was, ‘Only another surgery could fix that.’ And I don’t know why he said it that way, but many it’s because they haven’t paid him…because a doctor doesn’t [do that] …

Participants reiterated their frustration with being told by medical professionals that they were “okay,” or all better, when they were still unable to carry out daily chores, let alone manual labor without pain. Some participants were told by their doctors they could return to work without accommodations, even though they felt they were being put in more danger by returning to work injured. In Eliana’s case, because her employer had no workers’ compensation insurance policy, she suspected that because the doctor may actually be denying her care because he has yet to be paid.

Medical Examinations and Medical Definitions

Concepts such as Maximum Medical Improvement, and procedures like Independent or Impartial Medical Evaluations put physicians and injured workers in situations alien those of a traditional relationship. Maximum Medical Improvement (MMI) is difficult to translate to patients regardless of their primary language. MMI is defined in Rhode Island General Laws § 28-29-2(8).
Maximum medical improvement” means a point in time when any medically determinable physical or mental impairment as a result of injury has become stable and when no further treatment is reasonably expected to materially improve the condition.

However, reaching MMI rarely means that participants felt they have recovered fully, or enough to return to work. Jorge describes one of his last interactions with his doctor.

It got better, and now I have my hand at a three for pain [on a ten point scale], and that that’s sufficient… And a two for my neck and head. Either way, that will stay. But I told him that it still bothered me…I guess either way one has to get used to it, because now when I’m not working, and I do any little thing at home, it swells up. Preparing some food, it swells up, when I grab something hard, it swells up this much…

Generally, patients are dismayed to hear doctors describe their daily and ongoing pain, limited mobility and loss of strength as part of a “successful recovery.” Additionally, if an injured worker reaches MMI it is possible that their weekly workers’ compensation benefits will be reduced or discontinued, and limits will be imposed on his or her medical care. It is expected that workers would be participating in vocational rehabilitation and retraining if they are unable to return to their original job, and lawyers can petition for their clients to continue receiving benefits during rehabilitation. However, for injured Latino immigrants, the time needed to train in another skill often requires long-term prerequisites like learning a new language, acquiring written language skills, or earning a GED, and this can introduce barriers to accessing benefits during their retraining.

Returning to work with “restrictions” or on “light duty” sounds ideal from a legal and social perspective, as employers are asked to make accommodations for injured employees, and employees can then return to work sooner, but without risk of further injuring themselves. However, several participants found that light duty work was not a realistic option. Alvaro was told he would be provided accommodations, but received none upon arrival, and others realized that light duty work might only be provided for a short stint of time, and that workers were
expected to return to full capacity before they felt ready. Another participant returned to work on light duty, but then noted that his hand started swelling once again, and that little by little the pain started returning. Three other participants were fired while on light duty, which contradicts the purpose of the designation.

Independent and impartial medical evaluations present another situation where doctors serving as examiners—are supposed to act in a very different capacity than treating the injured person. In order to avoid criticizing the treatment a patient has received, impartial medical examiners are expected to follow guidelines that indicate they will not discuss ongoing care, or the results of his or her evaluation. This is understandably a difficult circumstance for physicians and patients alike. Sandra discusses her experience at an independent medical evaluation.

“Well, the insurance company asked me to go get a test done with a doctor at Rhode Island Hospital. And do you know what the doctor told me when I was about to ask a question? ‘Please limit your question. I know you have many questions…I am here with you based on the law, and by that law I am here just to collect information.’

**Parallel Systems of Care**

The separation of a person’s work-related health problems from other health problems can seem counterintuitive. Often this is mediated by the different payment systems that are in place for medical treatment. Alfonso describes that, “The doctor said he can operate my back but it would have to be with private insurance because the back problem wasn’t due to work.” Another example of how payment schemes can interfere with injured workers’ access to care is the requiring preauthorization. If an insurance carrier has a preferred provider network (PPN) approved by the Workers’ Compensation Advisory Board, injured workers who want to change their doctor chose from their insurance carriers’ PPN or have their request to see another doctor approved by the insurance carrier. At a meeting of the Injured Workers Committee, Cristina discussed how she had spent one year waiting for approval from their insurance carrier to see
another hand specialist. Another patient has had to pay for treatment and medicines out of pocket because she could not wait for approval from the insurance company to continue treatment. Another common problem arose from doctor’s offices themselves denying care to workers’ compensation patients who are not preapproved by insurance carriers. Alejandro faced this problem when he was referred from the hospital to receive therapy at another facility. His lawyer called and made an appointment for therapy, but upon arriving he was told that because his case had not yet been accepted by his employer’s insurance, he would only be seen if he could pay $300 out of pocket or had private insurance. This policy is imposed by individual facilities in a response to fears of not receiving any payment from workers’ compensation insurance carriers in the case is dismissed or claim denied. Alejandro’s treating doctor had said that he needed therapy urgently, but he was forced to wait weeks until he received preauthorization.

All of these structural components of the workers’ compensation system complicated an already complex relationship between physicians and Latino injured workers. Needless to say that this is further complicated by a lack of rudimentary accommodations like language support. Carlos describes how these complicated interactions lead to increased distrust in doctors, “They want to just push me to get better fast, and I don’t know if they have my best interest at heart.”

Accessing Legal Aid

Survey participants had hired twelve different lawyers or paralegals in the region. They reported a series of problems including that that their lawyer did not communicate in a way that they were able to understand (ten participants), did not explain procedures clearly (nine participants), was incompetent (nine participants), was difficult to contact (six participants), and did not return phone calls in 48 hours (four participants). Three workers reported they were not provided with translation in court.
Contacting a lawyer’s office often proved to be difficult, with bilingual secretaries serving a key role. Participants described often leaving a message with a secretary and then having someone from the office call back later. The lag in communication can have ramifications for injured workers. For example, important messages relayed with short notice, like a call informing a client he was to come to court the following day, do not allow for workers to make necessary arrangements. This creates a problem if workers are not able to secure transportation in that time. Whether it is because they did not own a car, or because of their injury, many participants were reliant on friends and family for transportation. Other participants felt that they were out of the loop in relation to their case, as Sandra states, “It’s been months since anyone [from the lawyer’s office] has told me, look this is how things are going.” With waiting to hear back from lawyers being a norm, knowing whether to trust that a lawyer was taking appropriate action on his or her case, or not taking any action at all, was difficult to determine. Some participants would try to find a new lawyer if their current representative seemed to not take appropriate action. When Eric’s workers’ compensation insurance stopped covering a medication he was taking, his first lawyer instructed to pay for the medicine out of pocket without mention of contacting the insurance or court about this issue. He decided that his insensitive behavior, which ignored that he would not be able to afford paying for this medication himself, was an indicator that if he came up against bigger problems, his lawyer would not be supportive, so he

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<th>Table 6. Experiences with Legal Professionals</th>
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<td>12 Lawyers Hired</td>
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<tr>
<td>Lawyer did not communicate issues clearly</td>
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<tr>
<td>Lawyer was incompetent</td>
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<tr>
<td>Lawyer did not explain procedures clearly</td>
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<tr>
<td>It was difficult to contact lawyer</td>
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<tr>
<td>Lawyer did not return calls in 48 hours</td>
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hired another. As discussed previously, Eric returned to work on light duty only to be harassed daily by a supervisor. His lawyer’s reaction to his inquiries about this harassment also troubled him, and he subsequently hired a third lawyer. Alternatively, another participant, Jorge waited as instructed by his lawyer for news of a settlement or development in his case. At first, he heard about the reduction of settlement offers, and his lawyer warned him that he should not try to find another job or else he would jeopardize his case because the insurance company could have someone follow him. Ten months later, he had received no more than one benefits check, and his lawyer had asked him to come in to discuss a future court date. I attended the meeting as a friend and interpreter for Jorge. The following is a reconstruction of the interaction based on my field notes:

We waited over an hour to speak to his lawyer, and when he arrived we discussed some of the options Jorge had in continuing with his case. His lawyer sped through an explanation of how, if Jorge signed off on excluding his head injuries, this would be better for his case, and the court case would be cancelled. I stopped several times to ask for definitions and explanations of what was happening, and presented Jorge these options. Jorge agreed to do what his lawyer thought was best. And as the lawyer moved to pack up, I asked about what could be done from this point on. He explained that he might be able to petition for Jorge to be evaluated for loss of use or disfiguration. Alternatively, he told us that what would be best would be if Jorge could see a doctor that would recommend surgery, because at that point the insurance will be more willing to settle, but would have to pay out of pocket. This was not an option for Jorge, as he had not been receiving compensation or able to work for almost a year. Rarely did the lawyer refer to the details of Jorge’s case, often seeming not to recognize issues brought up by our questions. At the end, Jorge asked what he could do, could he return to work? His lawyer seemed surprised at the
question, and said that working would be the best option for Jorge, because he could show that he was attempting to find work, and also, if he was reinjured, he would be able to show that he still had problems connected to the first injury.

Leaving this consult, Jorge was very frustrated, as his lawyer had just contradicted the advice he had given him months ago. Jorge ran through a series of concerns and options, “I don’t know if I should wait to hear from him about seeing another doctor... think I have had enough and maybe I should just find new papers and find another job.” We paused to consider the consequences, would working under a new name mean he could even continue referring to this injury? What if he was castigated for fraud instead? Would he really be able to keep up with the work with his hands still in this condition?

In Jorge’s case, he left his lawyer’s office with more questions than ever before. His lawyer had done little to consider what this would mean for an undocumented worker, and all the implications of getting a new job. When another lawyer that works closely with Fuerza Laboral reviewed Jorge’s file, he found little else that could be done because Jorge had stopped attending his doctor’s appointments due to a lack of transportation. Workers’ compensation insurance should cover transportation to and from doctors’ appointments, but no one had informed Jorge of his right to this benefit until it was too late.

Another participant had been having ongoing back pain, but his doctor opined he was okay. He asked his lawyer if he would be able to see another doctor, and his lawyer replied saying that he could go to any other doctor, and added that he should be able to secure insurance now to Obamacare, and use it to access care. However, this advice clearly misrepresents the accessibility of paying for health insurance for an out-of-work worker, as well as the Affordable Care Act’s exclusion of undocumented persons. The specific barriers faced by low-income, and
immigration workers in the Latino community require that legal professionals acknowledge of the barriers faced by workers in these precarious situations in order to participate in effective communication and advocacy.

**Problems While Receiving Workers’ Compensation**

Of the twelve workers who received workers’ compensation benefits, three participants reported the unexpected discontinuation of weekly compensation, two reported workers’ compensation stopped paying for their treatment or medicine, and one reported workers’ compensation denied a doctor recommended surgery. These problems highlight that even receiving workers’ compensation benefits is only a small victory. While you receive benefits, the insurance carrier may ask for you to attend additional medical evaluations and tests. At 26 weeks of benefits, the workers’ compensation laws indicate that the Administrator of the court’s Medical Advisory Board will schedule an impartial medical exam (IME). The court also schedules another exam at a year of receiving benefits (Rhode Island Department of Labor and Training). Aside from these expected reviews, an insurance company may stop payments or cut off coverage and an injured workers’ lawyer would have 14 days to file a motion. Problems with workers’ compensation insurance are often intertwined with problems seeking care, as described at length above. Similarly, other challenges met while receiving workers’ compensation weekly benefits are interwoven with faulty communication with lawyers’ about when payment could be expected, and what to do when it is not received. As one participant described,

<table>
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<th>Problem or Situation</th>
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<tr>
<td>Received Workers Compensation</td>
<td>12</td>
</tr>
<tr>
<td>Were not provided translation in court</td>
<td>3</td>
</tr>
<tr>
<td>Weekly checks stopped arriving</td>
<td>3</td>
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<tr>
<td>Workers’ compensation stopped paying for treatment or medicine</td>
<td>2</td>
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<tr>
<td>Workers’ compensation denied payment of a surgery recommended by doctor</td>
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That is what has me confused, that [my lawyer] told me, ‘Don’t worry, if the check is late, a check will come with the amount for all the weeks together.’ But that didn’t happen, I got a check last Tuesday, and that the first check I’ve received.

Additionally, having to wait fourteen days after a missed payment before filing a petition in the court can be devastating for low-income workers who have quickly dissipating savings. Participants suffer and often go into debt with family members or friends to be able to meet ends meet.

Other workers who attended workshops at Fuerza or participated in the survey were further affected by the hollow Uninsured Employers Fund. The fund is intended to cover compensation benefits for employees who are injured but whose employers’ have no insurance. However, the Fund’s promise is relatively hollow, and if an employer files bankruptcy or is unable to pay for the corresponding costs of compensation, workers are left with no recourses.

This research demonstrates that insurance providers, health facilities, and the court, have policies that introduce complexity and challenges alongside opportunities for care and compensation.

Responses about Fuerza Laboral’s Role

Participants had all voluntarily approached Fuerza Laboral for guidance or assistance and felt that the work the organization’s work in the community was very important. Participants noted the importance of Fuerza Laboral’s worker’s rights initiatives, as they saw a lack of information was a problem they faced, as well as information about how to report injuries and file a claim for workers’ compensation. Other participants urged that organizing continues to be a necessary activity, “I think that if the community was more united, if we have had the same problems, with work and everything, we could have better working conditions as well.” Others
supported Fuerza Laboral targeting employers and “telling them what is not working well, that they have to provide treatment, and what they have to do if someone was injured.”

Some workers who, seeing that abuse was rampant at their previous workplace had attempted to share information with co-workers, and cautioned that this had proven very difficult, and that many employees were not willing to risk anxiety over losing their job to participate or attend meetings.
Chapter Six: Legal Professionals’ Perspectives

Lawyers and judges have been increasingly subject to study in anthropological literature, with their experiences contributing additional dimensions to the analysis of legal structures and the “workings of power and control” (Nader 2014: viii). In this context, members of the Injured Worker Committee and survey participants had many different kinds of challenges in interacting with their lawyers, often citing that they did not feel some lawyers really “fought” for their clients. Additionally, the challenges that clients face also impacted lawyers’ work, and in order to better understand the workers’ compensation system it is important to incorporate the perspectives of legal professionals and judges within system. Interviews were conducted with three legal professionals, one lawyer, one paralegal, and a judge who had collaborated with Fuerza Laboral in different capacities, from participating in community forums to running workshops.

Legal professionals generally considered the Rhode Island system fairly efficient – “our court system, it’s really easy, clear, and concise.” They identified several unique and progressive features of the Rhode Island workers’ compensation system, such as coordination with state-run Temporary Disability Insurance (TDI), compensation for scarring anywhere on the body, the Medical Advisory Board, the Donley Center, all of which are described in Chapter Two.

Legal professionals were aware of many of the challenges participants reported facing in our survey. This included acknowledgement of the connection of workplace abuses to the landscape of the low-wage job sector and the precarious position of undocumented workers.
Some of these factors are apparent in their concerns for propagation of the “myth of the independent contractor.”

Where, rather than put somebody on the payroll, pay them a wage, deduct taxes, deduct unemployment, and now the nice big issue is start to address all of the Affordable Care Act requirements, we’ll treat this employee as an independent contractor, we’ll pay them cash, and not worry about it…From the employee’s standpoint, they’re so desperate for work they’ll do anything to get a job. And if I say to you, you’re going to be paid cash, and we’re going to treat you as an independent contractor they’ll do it. And the third step to that, an undocumented worker, and they see it almost like it’s a good thing, because they have a little anonymity they wouldn’t have otherwise, which is understandable, but if they get hurt, it’s a nightmare.

The determination of whether someone is an independent contractor is one of the key legal issues that can determine whether a claimant is eligible for workers’ compensation. Undocumented workers and other contingent workers paid in cash have little “evidence” of formal employment (i.e. pay stub or check) and are more vulnerable to having an employer claim they were not employees or were “independent contractors,” as in Eliana’s case. As Mr. Encinas, a bilingual paralegal at a workers’ compensation law firm, explained, “That becomes a problem, but then you have something to prove, that they were actually an employee.” In court, the decision is not bound by what the employer claims their relationship to be, but is evaluated based on the definition of an employee, “If they’re an employee they’re entitled to comp. They’re going to wait longer to get it.”

Additionally, language barriers were something legal representatives identified as a barrier, but also attempted to correct for in their practice. Being bilingual, Mr. Encinas describes one of his key roles as an advocate, “the biggest thing I am able to do is communicate clearly with the Latino community.” Similarly, Mr. Leto describes his firm’s actions in securing on-staff interpreters, and efforts to provide important documents in Spanish. Mr. Leto also advocates for issues related to language access as part of the Rhode Island Association for Justice.
We got Spanish placed on what we call the non-prejudicial agreement, which is likely perhaps one of the first documents an injured worker might see, and it tries to call their attention to the fact that there is a statute of limitations on WC claims, and calls some attention to some of the rights they have.

Communication and language access issues, which worker participants also found problematic, fueled frustrations for legal professionals as well. Mr. Encinas shared an anecdote that illustrates how lacking language support and inadequate efforts at communication can strongly affect a case. He agreed to speak with a potential new client that wanted to hire a new lawyer because he had not received approximately hundred and fifteen dollars from disfigurement compensation. A few minutes into the conversation, Mr. Encinas discovered that in addition to the disfigurement, the man had scarring worth up to two thousand dollars.

The conversation kept getting further and further. Speaking to him in Spanish we realized that wasn’t his only scar, his arm had gotten caught and twisted, so when you looked at his arm normally, you’d see the arm, but when he twisted his arm, you could see there was a deformity in the arm from when the machine had grabbed him, it only left a small scar because that was the only place it cut him, but inside of his arm, was damaged, disfigured. And that all happened on the same day, and we wound up with seven thousand dollars, instead of the five hundred and fifteen dollars he didn’t even have… and it was all because of the communication. So the other lawyers had missed it all.

Another challenge participants identified was undocumented workers’ uncertainty about their entitlement to rights, and how this impacts claims making. Mr. Encinas describes his understanding of undocumented workers’ concerns.

Most of the undocumented people will not seek out their rights, because of the fear that they’ll lose their employment. The biggest concern, is that it’s hard enough to find employment where you’re documented, when you’re undocumented it’s even more difficult, and once you find it you don’t want to lose it.

His perspective once again underlines how structural factors affect claims making, and reflect the concerns of participants like Jorge and Carlos. Working with undocumented clients also meant having to dispel some concerns over having their immigration status revealed in court. While in Rhode Island the workers’ compensation court is fairly sensitive to this issue, the same is not
true of other court systems in the state, and thus legal representatives must balance explaining all risks involved, but also dispelling clients’ fears.

Additionally, legal professionals noted how undocumented workers were often unable to participate in some of the mechanisms that make the Rhode Island compensation system more effective, such as Temporary Disability Insurance (TDI), which provides some income that well-established and documented workers could access if their claim were contested.

Now they’re in a system, they’re reliant upon, where they don’t really have all the same tools everybody else does because they don’t have TDI available, even if that money was taken out of the paycheck, it couldn’t have gone anywhere that was going to benefit them.

Additionally, legal professionals noted that at times a delay in hiring a lawyer can also complicate gathering evidence and building a strong case for a client.

I met him at the hospital, he was thinking about what to do. The employer gave him 400 dollars a week for about a year. A year later he contacts me again, he wants to follow up with the claim. Basically, he was almost paraplegic, wears a colostomy bag here, has been opened up from the stomach up to his chest, had about 5 or 6 different operations, and the employer denied that he was working for him at the time. And they’re going to win that. We’re going to get him compensation, but it’s not going to be that… What that says is that, I got lucky, I found 911 calls from people here and here [on diagram of scene of the accident], they still had the tapes, they were already scheduled for destruction, so I got lucky that they hadn’t destroyed them yet. But I can’t find those people, to help me put it together. If he had done it, I would have got those, I could have found them, because they would have still been living there, it would have been fresh.

Additionally, all three legal professionals discussed the difficulties created by health facilities requiring preauthorization from insurance companies to see clients—“doctors are fastidious about not wanting to do treatment unless it’s been preapproved by the insurance company so they’re certain they’re going to get paid.” Mr. Leto noted that this was especially frustrating when clients needed relatively inexpensive treatment,

And I can understand if we’re talking about a major surgery that’s going to cost tens of thousands of dollars, but if we’re talking about x-rays, or some physical therapy, or injection therapies, things of that nature, I understand there may be instances where
maybe the doctor doesn’t always get reimbursed 100%, but I think the benefit of the system of working faster, and then being able to get the treatment done in a faster way, can help the patient, and the whole system will move a little bit quicker.

Lawyers observed many negative effects of requiring preauthorization resonating with workers like Alejandro’s experiences.

So your injury can last longer, if you don’t have somebody on your side getting those authorizations, so that the treatment can take place, getting prescriptions in a timely fashion, making sure they’re getting filled, so that you’re getting the prescription at the time the doctor wants you to have it, instead of two or three months down the road, things like that are very important to trying to get back on your feet.

Moreover, Hon. Ragan, one of the ten judges assigned to the workers’ compensation court, discussed how preapproval for medical care is an even more acute issue for non-English speaking employees.

At that point in time, my experience is that the language difficulties combined with the cultural difficulties, creates tremendous communication problems between the physician and the patient. And it’s often misunderstood to be just whining, when the employee has some legitimate complaints, but they’re not being voiced, and not being vocalized and understood.

While generally sympathetic and conscious of the many barriers Latino immigrant clients face within the workers’ compensation system, legal professionals' perspectives sometimes deviated from the experiences documented in our survey. Retaliation is one such issue. Judge Ragan noted that it was only after he began his community outreach work that he was able to learn about the problem of retaliation, “I decide the case, and that case is closed as far as I’m concerned. I don’t hear anything about it.” Aside from a few protections like the year-long right to reinstatement, workers who are retaliated against are left few recourses, including securing legal counsel and filing a whistleblowers suit outside the workers’ compensation court. This total divide between court systems contributes to a more difficult terrain for workers seeking to enact
their rights. Additionally, perhaps because legal professionals do not represent workers in such cases, it is possible for them to downplay the prevalence and likelihood of retaliation.

That’s a whole different area of law, wrongful termination. In the state of Rhode Island… at will employment allows an employer to fire you for any reason what so ever as long as it’s not unconstitutional… Because an employer is not allowed to terminate you because you exercised your right, and it doesn’t matter if you’re documented or not, although later down the road they may find a different reason if you give them one probably. If you are a real good worker, and this is the first time this happens to you, employers usually don’t get rid of you. It’s when they’re already looking to get rid of you that you’re going to go anyway. Because it’s hard for them to find cheap labor, because that’s what they get in return.

This perspective differs from workers reporting good working relationships that soured after an injury or claim. Such participants discussed a positive work environment, or being promoted and praised by supervisors before their injuries. Yet, this did not translate into more supportive and honest communication or proceedings after an injury.

As a judge, Hon. Ragan, J. discussed some of the specific challenges and ethical dilemmas he faced deciding cases. His personal experiences reflect decades of expertise as a lawyer and judge in the workers’ compensation court system, and also elucidated examples of the ethical dilemmas he faces in this position. Cases that make it to court are those where some aspect is being contested, and the only easy decisions are generally “the devastating injuries,” where there are preclusive presumptions of disability. Otherwise, deciding cases is a difficult analysis of what evidence was presented and dependent on the skill of attorneys and medical testimony. Judge Ragan described feeling helpless when witnessing ineffectual lawyers, “making hash out of what should be a good case, and knowing that this case could have been won, could have been proven, but it isn’t because the attorney has not a good job.” In fact, despite other insights or impressions, Judge Ragan named this one of the greatest challenges inherent to the position.
To this day, twenty two years after I started this, the most frustrating to be deciding a case based on the evidence that’s before me, we all know what goes on, that witnesses are coached—I’ll be kind—or ‘bought off’ if you want, but if that can’t be proven in court, I can’t do anything about it... And I’m not co-counsel for the employee, I’ve got to just decide based on the facts. Extremely frustrating in that situation. But seeing how it goes wrong, and fixing it are two separate things. I can look at how this one goes wrong; I can’t do anything for that case. All I can do is go out and do the community meetings and do a lot of outreach so people don’t get to that point. That’s incredibly frustrating.

Thus, the constraints of traditional legal procedure and its reliance on evidence create a situation where witnessing is possible, but advocacy is only possible through community engagement, not for individual claimants. In workers’ compensation cases, other than legal issues like determining whether there was an employee-employer relationship, the decision relies on medical testimony and analysis to determine the character and authenticity of an injured worker’s claim.

The problem with it is that we are dependent on the medical. So if the doctor looks at it, and the doctor discounts the pain, or the complaints of pain, we really are in a tough position to say, no, we won’t accept that doctor’s testimony, because we’re not doctors. And at that point that decision has to be based on the evidence that’s presented…

The Judge goes on to describe how biases and cultural barriers can jeopardize the integrity of a claim.

And it’s a very heavy job, but they don’t describe it well, or they just leave it at that. Or the employee thinks that they should be exaggerating the demands of their job, so they’ll go in and tell the doctor they have to lift 300 pounds. And if they told it correctly, that it’s about fifty or sixty pounds, that’s heavy lifting, it doesn’t make a difference, but they think they have to elaborate. They think they have to dress it up more than they do. And that becomes an issue because now it’s the credibility of the employee. And you have all of the other, again, cultural biases, and I don’t know why it happens, but different cultures approach pain and the affect of pain differently. It doesn’t mean the pain is any more or less between a Latino or a Norwegian. But the outward aspect is different, there’s a bias there, there’s no doubt there’s a bias in some situations.

Alternatively, despite the risk that biases that may come into play when physicians are evaluating Latino workers, Judge Ragan also noted that it is also frustrating if judges or lawyers attempt to act as medical experts themselves. He noted that as a judge he has attended courses on medical
issues and even attended surgeries, and as an individual he has also had a lot of exposure to medical practice, but that this did not qualify him to make decisions about health problems.

I’m not a doctor, and I shouldn’t be making medical decisions. And if we are not using a scientific determinant for these things, then we do get into those issues, where now people come and say, does the employee need surgery, you decide? How crazy is that? For a judge to decide? The doctors don’t agree, but it’s suddenly up to us to decide those issues. We use impartials [IMEs] a lot for that, to help us decide those issues.

The evaluations are seen as objective, quantified, and more trustworthy than other testimonies because they are supported by science. Simultaneously, judges like Hon. Ragan, J. appreciate individual physician’s capacity for bias in treatment and diagnoses and the vulnerabilities this engenders for Latinos and other immigrants. Additionally, as a judge, and representative of the workers’ compensation court he is additionally concerned with the cynicism that some people project onto physicians and patients. Most commonly, this includes assumptions that physicians overtreat and patients aggrandize injuries for financial gain. Yet, despite these concerns legal professionals are left only with limited degrees of freedom when they disagree with medical opinion.

These small number of interviews with legal professionals indicates that their experience is highly relevant to research focused on understanding the workers’ compensation system, and even significant in reflecting on workers’ own reported experiences.
Chapter Seven: Medical Providers’ Perspectives

Physicians treating patients within the medico-legal workers’ compensation system grapple with additional legal and moral dimension of practice. They see patients not only as a treating doctor, but often in their role performing independent or impartial medical evaluations, where they are in dialogue with the court and insurers in addition to patients themselves. Injured workers see a constellation of providers from their traditional primary care provider to surgeons and physical therapists throughout the course of treatment. I interviewed two orthopedic surgeons, a physical therapist practicing with a chiropractor, and the director of a community health center in a predominantly Latino neighborhood. In treating Latino immigrants, medical professionals face barriers related to those confronted by workers when seeking care. For example, they also face challenges to providing care resulting from complicated payment schemes and language barriers. Medical professionals have access to biotechnical tools that and evaluations that may either support workers’ claims or contradict workers’ experiences. Additionally, while lawyers and paralegals are afforded the opportunity to advocate for their clients regardless of their doubts about an injury’s severity, medical professionals are often asked to formally evaluate their patients’ credibility. Dr. Taylor, an orthopedic surgeon, describes his views on the complexity of workers’ compensation for physicians and patients alike.

Well, worker’s comp, even leaving the Latino, or other difficulties out of the situation, is a difficult system to work in, because the people are under duress from the fact that they feel their job is in jeopardy, or that they are going to be fired, or that they are going to be hurting their employers by claiming worker’s comp, and all those kinds of things, so automatically there’s a very adversarial relationship in the worker’s comp system, compared with just the patient-doctor relationship. … Normally, when you are seeing a patient, you’re on their side, you’re 100% for them, and we are generally even in worker’s comp, although I feel that a lot of the people, the patients, feel that we might not
be, because they were steered here by their employer or something like that. Which isn’t true for everybody, and they’re not all steered here by everybody, so I think workers’ comp as an animal, apart from just being a doctor, is a whole other level of complexity for those reasons.

His observations indicate the ways the structure of workers’ compensation insurance and care seeking produce additional ambiguities, suspicion, and complexities into clinical relationship.

Dr. Walton, another orthopedic surgeon, explains how providing care for workers’ compensation patients is interposed with interactions with insurers, even for the first appointment.

But I saw a guy today, who chopped off his index finger, two months ago, has not seen a doctor since, he has a scab at the end of his finger, and I got a letter from the insurance company saying, “why is he not back to work?” I’d never seen him before, he did this two months ago, and he hasn’t seen anybody because there’s no follow up and I’m supposed to just…? I said, ‘Look, I just saw him for the first time, he has a scab on his finger, which has to come off first, he has to do therapy, he can’t help it that he’s been sitting for two months, that’s not his fault or my fault, I’m starting from square one today, not two months ago, because now’s the first time we’ve had the opportunity to affect his care.’ So delayed treatment, or incorrect treatment initially is a huge problem.

Thus, collaborating with insurers can at times be frustrating. Dr. Taylor reported frustration when insurance adjusters or lawyers accompany patients and make off-hand remarks insinuating the physician is not doing a good job, puts “an automatic feeling of non-trust in the doctor patient relationship.” Yamila, a physical therapist, noted that she felt that when patients become frustrated by the inconsistencies introduced when they are involved in therapy but were asked to see another doctor by their insurance. If told nothing is wrong with them, Yamila felt “that’s when I feel that the case hits a wall, because the person, the little progress they’ve been able to make, will worsen.”

Independent or Impartial Medical Evaluations (IMEs), which posed confusion and frustration for worker participants, also presented ethical challenges for physicians. Dr. Walton emphasized how it is important for physicians to be “kind of be in the middle,” and use a measured judgment to distinguish between patients who need more recovery time and those who
“really should be healing up quicker.” Thus, the timing of an injury and its symptoms is a point of departure for speculation into a patient’s claim. If a patient’s experience is outside the range that a doctor or studies identify as ordinary, that patient is likely to face more suspicion. From medical treatment, to legal proceedings, our results indicate that the timing of an intervention or services received is critically important from a biophysical and legal standpoint. How and when different procedures, including IMEs, cause delays for injured workers is an important factor that merits ongoing observation and investigation. IMEs were similarly the source of much confusion for workers like Sandra, who were baffled by how quickly and briskly they were evaluated. Dr. Walton explained that there are some injuries that he feels can be evaluated in seconds.

Where I can be in there for twenty seconds and I know exactly what is going on. But it has to be a very focal problem, very specific. And when I see patients, they’ve already been seen by the resident, and my physician’s assistant before me, so they’ve already had two people look at them, so I get a little pre-information, so I’m already clued into what’s happening, so I focus on the things that are the problem. If it’s a very straight focused thing, like chopped off finger, you don’t have to examine their elbow. There’s a lot of things you don’t have to examine because there’s a fingertip, a wound, a wound looking at it takes one second, touching it takes two seconds, asking them to bend, and seeing how much their motion is takes, two seconds, asking them how they feel while you’re doing all that takes two seconds, and checking their bone is two or three seconds, and looking at the x-ray, is five seconds.

He goes on to say that there are other injuries that involve crushed bones or damaged multiple tendons that require up to twenty minutes of evaluation, but that generally the guidelines of conducting an IME can feel incompatible with the role of a physician.

So in an IME, you’re not really supposed to tell [the patient] anything, that’s the theoretical. I break that all the time. If I see one who either has the wrong diagnosis or they’re not getting the right treatment, I tell the patient. Frankly, I feel as a physician I don’t feel right just ignoring you. I sit here and say, “I think you need an injection for this problem, I suggest you tell your doctor to consider that next time you see him.” I do it in the nice way, and in the IME [report] I tell them what should be done, but I tell the patient too, “You know what, I don’t think this is the problem, I think this is the problem, when you see your doctor again maybe you should discuss that.” You’re not supposed to do that, but as a doctor, I just can’t not do that, I don’t think it’s ethical… If it’s your [treating] patient, I think you have to tell them everything, you have to treat your
workers’ comp patients, just like a non-workers’ comp patient, I mean, they’re a patient. If you don’t tell them what’s going on, you’re doing a real disservice, because that’s your job. In a patient-doctor relationship, there’s no ‘don’t talk to them.’ If you’re not talking to them then you’re doing a bad job.

The IME guidelines were formulated in response to complaints from physicians that medical evaluators had “interfered with the treatment process at the time of evaluation, including untimely and at times critical comments concerning prior treatment,” and that evaluators had “suggested alternate forms of treatment and on occasion have attempted to take over management of injured workers’ care” (Medical Advisory Board). The guidelines, which instruct evaluators to not discuss results or ongoing care with patients, are meant to maintain the integrity of evaluations themselves. However, Dr. Walton’s statement and the experiences of injured workers surveyed illustrate how the ethics of a physician-patient relationship may not be adequately accounted for in the procedures.

Another aspect of the workers’ compensation system that affected all medical professionals and workers alike is payment for services within a market-based healthcare system. Most injured workers surveyed as part of this research project made no mention of a primary care provider they saw regularly before injury, but those who had most likely attended the Blackstone Valley Community Health Care (BVCHC), a federally qualified health center with offices in Pawtucket and Central Falls. Dr. Perez, a physician from this health center, noted that while the majority of their patient base was Latino, he felt he saw few cases of workplace injury, and instead “lifestyle” health problems like diabetes and obesity were of greater concern. However, when patients did report that their injury may have been related to work, a coordinated shift takes place in how physicians and administration approach the patient.

If they want to say that it’s directly related to their job, that’s when it changes how we document our visit here, and how we bill for their visit here. Because that’s them saying, my insurance is not going to pay for this, I want the company to pay for this, and it starts
the ball rolling in a whole different direction for a bunch of people that we have that just do the billing... I don’t expect a payment on this visit, who knows, it could be years, if it’s a question of who is responsible for these visits. It changes our, business standpoint for the visit.

The complexity of billing is important to centers like BVCHC because as a provider of care to uninsured patients on a pay scale, and with limited funding from the federal government, the administration fears the less reliable payments from the workers’ compensation system.

That’s the reason why in the regular insurance side, there are more mechanisms that protect us a bit more, so we have a 30-day window to submit the bill, and then we have a sixty-day window for them to respond, this is just regular insurance, and then we have a 30 day back to appeal. So there’s a more fixed dates for when I can expect that money to come from Blue Cross, and it’s more set in stone. The insurance for the company, in a worker’s comp case, its all dependent, and god forbid there’s a lawsuit involved, and then it could be we’re not paying until this settles out with the judge and lawyers, and you could be looking at three years for the services we provided. And of course, the people who look at me, the Board of Directors, isn’t happy with that because they’re like, we’re giving services we’re not sure we’ll get paid for.

This leads this particular health center to “steer” patients injured at work to visit occupational health centers like Concentra Urgent Care or ask their employer where they should go for care. This arrangement is seen as beneficial because occupational health centers already may have special contracts negotiated with employers and their insurers, and the health center is not left without payment. Mr. Perez opined that workers might benefit from receiving specialized non-primary care at an occupational health center, and that, “it’s also better for the company and for us.” Yet, such referral networks are likely to complicate the process of seeking care for injured workers. Considering the importance of timing for medical treatment and diagnosis, being referred to another health center may actually lead to more frustration and delays for workers, and may not be in their best interest. The clinic’s policy also helps explain why Concentra Urgent Care Center is one of the most frequently visited health centers in our survey. Steering injured workers to specific health facilities or specific providers increases suspicions among
workers, and as Dr. Taylor noted, can subsequently contribute to the deterioration of trust within the physician-patient relationship. Additionally, this phenomena could produce complex ethical terrain for providers with “dual loyalties” to their employers and patients (London 2005).

For specialists in the system, payment through workers’ compensation insurance has led to other complications. Dr. Walton discussed how providing treatment for injured workers before it is authorized by the insurance company means doctors risk never being paid for providing services.

For docs like me, if you don’t get the preauthorization, what does the insurance do? You could be treating them, treating them, but we’re not paying. And then you’ve got, as a business, medicine is a business like anything else, if you’re putting time and effort into it, and you get no money, you can’t survive as a business very long like that. So a lot of docs say, we need some type of authorization, or verification this was a work-related injury, before we’ll treatment, because otherwise we’re in limbo land. It used to be twenty years ago that wasn’t such a big issue, and now it’s a big issue they just won’t pay you. Twenty years ago they’d eventually pay you, but now they won’t. So unfortunately, it’s like business has over taken medicine.

These decisions often affect vulnerable workers, who are more likely to delay treatment or pay out of pocket for expensive medications and treatment. As those with alternative insurance may be able to access care, these policies affect uninsured workers most drastically. Even so, some health facilities, like Dr. Taylor’s practice, no longer see patients under private insurance for work-related injuries while waiting for their case to be decided.

So I’ve had cases, they’re somehow fighting who’s responsible, and eventually the judge says, half of it is caused by work and half of it is caused by his life. So worker’s comp is in charge of half of the payment, and Blue Cross has to pay the rest. But the fee schedules are all different. So half of workers’ comp doesn’t equal half of Blue Cross, so Blue Cross ends up paying you half of what they would normally pay, and worker’s comp ends up paying half of what they would normally pay, and you really get like three quarters, of what you would have gotten. So it’s not really worth doing. If they’re not comp, I’m not treating them under comp, and they have to be authorized ahead of time, because I have no recourse to fight that battle, that’s a problem.
Concerns about not getting paid thus push doctors to focus on the business of medicine, and turn patients away who lack authorization from insurance carriers. Considering the intricacies of market-based medicine, the Rhode Island workers’ compensation system does well to compensate physicians well by maintaining competitive fee-schedules, but the uncertainty of payment from insurance carriers has detrimental effects for workers by limiting injured workers’ choices in health provider and putting physicians and health facilities in a situation where they risk never being paid. This could potentially also decrease the quality of care workers receive.

Apart from the general convoluted nature of the system, participants were eager to share what they had observed as challenges for Latino immigrant workers and doctors in the workers’ compensation system. The quality of communication was complicated when working with Latino immigrant workers, especially when clinicians were not bilingual. Dr. Walton explains how language skills were not part of the curriculum when he attended medical school and especially less likely in non-traditional immigration destinations.

Because if you’re a physician in Florida or South Texas, or Southern California, you probably have to learn Spanish in your classes to be practical because the populations are overwhelming. In the Northern States, it’s a lesser issue. When I went to school, there was no Medical Spanish, my daughter who just graduated from medical school, she had to take Medical Spanish, but they didn’t have that when I went to school. So I don’t really know how to speak Spanish, I’ve kind of picked things up here and there, you know, from my patients. But language is a problem, sometimes the patients they may feel that as much as we try that they can’t express their concerns as well with somebody like me who doesn’t speak Spanish, as opposed to a Latino physician, or a lot of time we’ll ask that there’s an interpreter there because it’s important to get the story right, you can’t really treat them right.

Dr. Walton felt limited by his inability to communicate with Latino and other immigrant patients who may not be fluent in English, but despite these concerns about the importance of language accessibility, he found himself working with untrained interpreters.
Frequently, I’ll have an eight-year-old kid, translating for their mom or dad, that’s really common, because the kid knows how to speak English, great, so that’s one issue that I think is particular for that community.

While having an interpreter present requires additional steps and coordination for health professionals and facilities, there is no doubt that having a first grade student serve as an interpreter limits discussion between physicians and patients. Dr. Taylor, also orthopedic surgeon, explains how communication between physicians and patients is already complex, but that language barriers affect the quality of communication when family members who are not fluent in English serve as interpreters.

Even if they’re in here with a family member, with a substantial language barrier, the entire family has a substantial language barrier, it’s not just the worker, so he’s in with his brother, sister, or wife, but they’re still only getting half of what we’re saying. When I’m treating a patient, if I was treating you, and you had a complex medical problem, it’s very hard for me to tell you what’s the matter with you in plain English, I can’t do it in Spanish. They can’t understand my English. It’s very difficult. If we look at a normal patient and we look at an informed consent studies, I talk to a person here, and they go out and register, and we give them a test right outside, five seconds later about what I told them, most people only know about 20 percent of what I said, if it’s a language barrier thing, they must not know two percent of what I said, because I barely said anything they understood. So that’s a big problem.

For both physicians, the identification of language barriers as affecting the ability of injured workers to gain adequate medical care, but using adequate interpretation is not seen as a possibility. Dr. Taylor explained, that in-person interpretation for many languages was an unsustainable amenity for a medical practice.

We have a lot of people working here who can speak fluent Spanish, Portuguese, but not Cambodian, Laotian, so we can’t interpret for everybody, and I can’t begin to go hire an interpreter for all these people, because we don’t have enough to make that a legitimate way to run business.

Despite having staff available that could interpret for Spanish speaking patients, Dr. Taylor also told me that it was common to have “eight, ten, twelve years olds” interpreting for their parents at his private practice. However, Yamila, a physical therapist working at a chiropractic practice,
noted that her supervising doctor’s private practice did hire interpreters for the most commonly spoken languages, and explained how this was part of greater efforts to understand patients’ cases as well as possible.

Here are always interpreters, only for Spanish, Portuguese, and Creole. We are always attentive, and the doctor concerns herself with the well-being of all patients and she is cares that every workers’ compensation case is as clear as possible so that she is able to understand the person’s condition well. That is why I work with her.

Yet, even with interpreters available at the center, Yamila has found at times that patients are more forthcoming during physical therapy sessions than with the doctor and that she is able to share additional information with the medical team.

When I’m doing therapy, I take the opportunity to talk to them, I feel I have to, because people want someone to talk to. From there I more or less by asking questions like how are you feeling? And they tell me, ‘Well, I feel very bad, this is hurting.’ And I ask did you tell the doctor? Did you report it? Tell me when you come here if something hurts, and I will explain the medical terminology. If you have a lower back injury and later your knees hurt, please tell me, so I can make a note. Other times it’s with the doctor. She says, “How are you doing?” And they say, “Yeah, I’m okay.” Because they don’t understand, because they don’t know, and they feel embarrassed. But when they come to therapy I tell the, tell me, what happened, what hurts most, and thank goodness we have been able to figure out that at times people had more than one injury.

Communication thus incorporates more than simple language interpretation, like when working with legal professionals, space made for conversations with patients or clients can result in better legal and medical outcomes for individuals and professionals.

Those practicing within the workers’ compensation system discussed “cultural issues” as another barrier for Latino immigrant workers. Often, culture was invoked regarding how pain is expressed, tolerated, or experienced. As discussed by Judge Ragan, and in concurrence with the conflicting experience of many worker participants, pain discounted or supported by medical professionals can have great reverberations through the legal system. Thus, I review physicians’
quotes about evaluating pain as part of the workers’ compensation system, and then move on to
discuss more thoroughly how they employed the concept of “culture.”

In general, medical professionals reported intuitive and pragmatic ways of “knowing”
when patients are in pain and differentiating this from patients exaggerating or feigning pain.
Yamila noted that as a trained therapist “you more or less press, and the body speaks.” She goes
on to describe how true pain can even be apparent when looking at a patient.

Just in looking at a person, I know: you haven’t slept well, you’re not doing well, and the
person tells me, ‘Girl, it’s been three days with this pain, it’s been three days that I don’t
get out of bed, I haven’t slept in two nights, I can’t sleep.’ …You notice when a person is
truly injured.

Dr. Walton discusses how he bases decisions on when to include pain in his medical report and
when to discount it based in part on his expertise, “I’ve got a subset of 500 to 1000 people I’ve
treated for the same problem.” From this knowledge base, he arrives at a flexible idea of how
long an injury might take to heal, and what can be hoped for an eventual outcome.

When people are in that range, I don’t discount the pain, it’s when people get 50% of the
range, is there (A) something I’m missing, or (B) are they pulling my leg and just trying
to game the system? If they’re a little outside of it, I don’t care.

Yet, when patients’ recovery time begins to grow past a point of comfort, Dr. Walton reported
using a few different types of tests for some signs of malingering.

But if they start to get a lot outside of it, let’s say something normally heals in three
months, and they’re six months now, I start to get a little bit [worried], and then I’ll do
things like, like I’ll talk to them, and I’ll distract them while I push down on their finger,
so they think I’m doing something else, I’ll distract them, if I just hold it like this, and
their looking at me, and I go, does this hurt? ‘Oh yeah, it hurts’, and then I say, I’m going
to push on your neck now, and I squeeze their finger at the same time, and they say, ‘Oh
my neck hurts.’ Nothing is wrong with the neck, but while I’m squeezing their finger,
they didn’t say my finger hurts, so you can use little hints like that, where you start
saying this is not right, or you push on an area where there is never a problem, there’s
some anatomic areas where there’s no tendons, nothing can be wrong, or it can’t be
relating to the problem, well if they have pain there too, then it’s not anatomic, it can’t be
real. There’s a little game going on. And then I listen to the pain less, I’ll be honest with
you, a patient starts saying to me, and I kind of start in my own mind, you’re kind of
playing me for a fool, I’m not going to listen to you as much. If I think you look good, I’m going to go purely on the objective things, so I kind of cut them off at a certain point, and I don’t really know, I’m using external clues to make that decision, but its not foolproof. I’m sure I’m wrong at some percentage of the time.

Dr. Taylor noted that some anatomical information can be used to dismiss some claims of pain, “If you injured this nerve, it has to go here, it might go a little further over, a little over there, but it doesn’t go everywhere. So there are objective ways to measure is their statement even close to being true.” He also reported using less standardized tactics to gain more “objective” information about injured workers’ pain, and gain a better understanding of whether pain is truly a problem.

Yes, it’s very difficult, so the more we can point out some objective things, and then they seem to use their hand perfectly fine, or a distract them and they walk down the hall just fine, and then I say, your ankle hurts, so let me see you walk, and he starts to limp around. That’s different. Somehow he’s lost the connection there. If you take those things out it can be very helpful to everybody. And in our opinion we can say, I am discounting his subjective complaints because objectively he actually can do all these things, just when you ask him to really do it and look at it he’s over here, when he’s not thinking about it or when I see him walking across the parking lot, I see he’s perfectly fine, somebody’s playing a game against something. Intentionally or not, it’s not always intentional. Sometimes it is completely they’re so invested in their injury, it’s the only thing keeping them afloat right now, they have to be sure it seems like a big injury.

These examples highlight physicians’ role in analyzing not only a patients’ condition but also his or her character and the difficulties involved in doing so objectively. Drastic and severe injuries, with anatomical correlates, are more easily recognized as “real injuries,” but sometimes still contested by insurers and employers. Dr. Walton again explains how he sees two frustrating poles for patients he treats through workers’ compensation.

I get people, it frustrates me to no end when I get a person, a hardworking guy, you know, 25, works in a factory, chops off his finger. It’s not a fake injury, it’s a real injury, I can look at it and tell it’s a real injury… I mean my kid, who’s four years old, could tell you there’s a problem, it doesn’t take a rocket scientist. And the insurer wants them to go back to work the next day. That’s not reasonable … And there’s some injuries that come in, and it’s like I hit my hand on a cart, and I’ve got massive pain here, and you know, you can’t find anything wrong with them. You take an x-ray, and there’s no fracture. And you’re kind of going, hey, come on, a week or two, and you should be back to work, for someone who gets a contusion, those you worry about.
Because pain is generally less understood physiologically, and because it is seen as an inherently subjective experience, pain was the subject of the most variance and confusion in diagnosing, evaluation, and treating illnesses. Medical professionals reported pain as an arena that exhibited cultural differences between Latino patients and others, “I do think that there is one thing to point out in orthopedics, there is a different response to injuries that we see or stereotypically see with Latinos.” Both orthopedic specialists reported that this belief was held widely by colleagues.

This sounds kind of weird, it’s an impression that a lot of docs have, that for some reason, [Latinos] seem to have a greater amount of pain than other patients with the same amount of pain. And I don’t know if that’s cultural, or ethnic, or something related, but that’s not just my impression, but a lot of people’s impression. Not that they can’t function at the same level, they just have more pain. The injury, if you took the same injury in two different patients, they tend to have more discomfort, maybe that’s either that I’m not understanding them completely, or maybe they express themselves, what they’re thinking the pain level is and what I’m understand it is not the same level, an English speaker I can get it exactly, I don’t know, pain seems to be more of a problem with Latino workers comp, than with an Irish guy that chopped off his fingers. The rest of it is the same, their function, their outcome, how well it heals up, how sensitive they are, that’s pretty much the same, it’s just for some reason pain seems to be a bigger barrier for us to deal with.”

Doctors expressed uneasiness with making these generalizations and were careful to avoid insinuating that they believed Latino patients were exaggerating pain. Instead, they emphasized that these differences might be cultural or due to language barriers, but also stressed that they seemed to hold true. Dr. Taylor describes his observations at his practice and within academic medicine.

So I do think that there is a cultural difference. In that a so-called American, or European, mostly is discouraged from expounding from how much it hurts, I find many Hispanic males will not have that, and actually seem to have a lot more expressive pain things. Now whether that is real, just the way they were brought up, the way they express themselves, I don’t know. Often I do see that we often get a number of family members that come in with the patient, the Latino or Hispanic groupings, where I don’t think that almost ever happens otherwise, and partly they’re there to translate or help understand what’s going on, so that’s a lot of the reason I often have more family members in my
exam room that I would otherwise… I also think that in orthopedics, and it’s often said, perhaps stereotypically…that there seems to be a much higher percentage of Latino and Hispanic backgrounds that go into this Chronic Pain Syndrome scenario than not. And it’s difficult because often there is quite a language barrier so it’s hard to get to the base line of what’s really happening, but that’s definitely think that is something I would say anecdotally I would see at my practice. And pretty much throughout the world of orthopedics, when you go to conferences, and people talk about it, everyone has somewhat of that thought.

Despite these uneasy generalizations, physicians were also unclear about the differences between the designations of “Latino” and “Hispanic,” and Dr. Walton, for example, contradicted his own observations by singling out different experiences with specific nationalities.

I’ll tell you, the Guatemalans I’ve treated, they are tough as nails. They don’t complain about anything, they’re like Iowa farmers. Iowa farmer comes in with a hand chopped off, he goes, ‘When can I go back to work, doc?’ They are like that; they are tough as nails. There’s a culture, it’s not—they may be Latino, they may be Hispanic, but they’re not the same as a Mexican, or a Nicaraguan, or a Brazilian, there’s something there. That’s why you’re doing your MA right?

These perceptions affect doctors’ interactions with their patients. A high proportion of Latinos constitute those seen with chronic pain syndromes, indicates an attempt by doctors to validate their experiences acknowledging the lack of physiological markers. However, expressing more pain can also complicate physician and patient relationship. Dr. Walton considers that when a patient focuses exclusively on pain, it may be easier to tune out complaints.

And in the case too, I think human nature is that, that I think that if I hear my next door neighbor whine constantly about my dog barking, over and over and over again, year after year, “your dog, shut your dog up!” You know, pretty soon, I don’t hear it anymore, I got a dog, I don’t want to hear about it anymore, I become immune to it, I think about the same thing with pain. If a patient is always like, “pain, pain, pain, all I got is pain, doctor, the pain, pain, pain.” They don’t say, my finger can’t move, I can’t open a jar. I think people start to kind of ignore it, because they say, “Listen, all you do is talk about pain, but it’s out of the norm, but it hinders their case sometimes, because the person says, ‘this person is just a pain whiner…

Dr. Taylor discusses that knowing that a Latino patient is more likely to have worse outcomes related to pain affects how he approaches new patients.
So I see a fingertip amputation, that’s a painful thing, everyone has pain, everyone has residuals of sensitive finger, cold intolerance, trouble using their hand. If that happens in a Hispanic person I have a lot more dread going through that whole thing than I do in a non-Hispanic person, as the treating physician, when I see that injury in that person, I think, ‘I’ve got more trouble here than I normally have.

Alternatively, Yamila, who is Latino herself, reported contradicting observations about differences between Latino and Caucasian patients.

[LATINO PATIENTS] only begin to comment [about pain somewhere else] but I basically have to pry it out of them, because they won’t mention it on their own, they don’t connect the two…It’s very different when it’s a [white] American. An American will say I have pain in my foot that goes all the way to my eye.

Yamila’s perspective helps contextualize the types of observations both orthopedic surgeons reported being wide shared in the profession. Yamila voices biases about white Americans instead of Latinos, the converse of the biases expressed by white American surgeons. Each professional brought with them their own biases relating to patients of different backgrounds.

Yet the homogeneity of medical specialist who work with injured patients in medical-legal system, such as orthopedic surgeons, affects the degree to which biases about Latinos can have on medical practice and treatment. For example, only 3.5% of residents, 2.3% of clinical faculty, and 6.8% of research faculty specializing in orthopedic surgery were Latino in 2010 (Daniels, et al. 2012; Day, et al. 2010). Aside from deficits in medical education, Latino and minority underrepresentation in medicine could potentially help explain the prevalence, acceptance, and power of biases that health care workers grapple with when caring for a diverse group of patients in a clinical setting.

Medical professionals were empathetic and voiced consideration of the social context for low-wage workers alongside the acknowledgement of language and cultural issues discussed above. However, some of these considerations were incomplete, and often blended with
misunderstandings and cynicism relating to the workers’ compensation system itself. For example, Dr. Taylor, found it difficult to understand why patients did not bring a friend who spoke English fluently to appointments, and instead brought friends with limited English skills. Both surgeons and the physical therapist interviewed voiced concerns about incentives and corruption in the system perpetrated not only by patients but also fellow physicians, and attorneys. Yamila worried that lawyers would mishandle cases, and as Dr. Walton explains below, he was concerned that lawyers and doctors were incentivized to keep people in the workers’ compensation system.

A lot of the lawyers who do workers’ comp, they want everyone to be out forever, because they want a client forever, they can collect money, every time they go to court, they collect money. It’s a self-fulfilling prophecy, if you get paid to do X, you do more of X to get more money. And the defense lawyers, they don’t mind it because they get paid by the company every time the guy goes to court, so they’re getting paid Y, to do Y every time. So both sides, they like this system because they’re both getting paid. Doctors, we’re no better, we get paid to do surgeries, to see patients, so if you see a patient … So the system right now, people are paid for creating work.

This sentiment’s irony, where one’s inability to return to work fuels and is fueled by the system intended to resolve his or her predicament, illustrates how cynicism colors participation in the workers’ compensation system. Cynicism most commonly describes doctors and lawyers’ roles in the system as detracting from an injured worker’s well-being. Doctors and lawyers are seen as incentivized to prolong legal battles and ineffective medical treatment. The cynicism voiced by surgeons focused most on this self-critique and questions of evaluating whether a patient’s claim was valid, with limited critique of employers and insurers’ role. Yet, some of these described incentives for lawyers expose ignorance of the details of, for example, how attorneys are paid in the workers’ compensation system. As Mr. Encinas noted, the majority most workers’ compensation cases are settled through a denial and dismissal process (RI Gen. Law 28-33-25.1). The ability to settle a claim combined with support from TDI does allow a
worker, who is documented and has private insurance, and who sustained only a minor injury to receive adequate care wage-loss replacements for a short period of time along with a settlement amount. However, the most notorious attorneys in the field are those that abuse this mechanism by taking on too many clients and settling cases quickly, without consideration of the type of injuries and their consequences years in the future. By spending less time on each case, and being able to be paid quickly (up to 15 percent of the settlement amount may go to legal fees), they are able to profit more than by attempting to keep a client on workers’ compensation for longer. Jorge’s lawyer is known for using this method, and thus it is unsurprising that his advice for Jorge was to seek a recommendation for surgery from a doctor in order to settle and exit the system.

Additionally, Dr. Taylor discussed how he feels that poor working conditions, and limited job opportunities incentivize injured workers to stay in the system.

And they try to devise the money part to be incentivizing people to go back, when you get to three months, you say, okay, you’re done, but you can’t go back to that job, they cut their pay to whatever the percentage, which is killer for the person, and they still don’t have a job to go back to. So it’s all a mess. So they come back in saying, it’s actually killing me way more, because they need their number to be way higher than it is, so it makes them exaggerate their illness, because again that’s their only life line.

He goes on to say how such social conditions lead workers to “invest” in aggrandizing their injuries because they do not want to go back to a horrible job, and “they are actually doing just as well not being in the job, which is a fault of the worker’s comp system, particularly in low-paying and worse jobs.” However, as participants’ experiences demonstrate, it is particularly low-wage workers who suffer most from inconsistent access to workers’ compensation, higher rates of having claims contested and from reduced weekly benefits. While workers did report difficult working conditions, having no savings meant continual indebtedness to family members and friends if they chose to file a claim or seek medical services on their own. Participants also
reported feeling depressed and having to adjust to a much less active life after injuries. Similarly, while it is difficult for all workers to adjust to receiving 75% of their weekly wage, low-income workers are likely to drop below minimum and living wages at that rate. For example, this study’s participants who had an average wage below $10 an hour, would only receive payments equal to less than $7.50. In Rhode Island, this would constitute poverty wages for an adult with one dependent. Living on reduced wage benefits is thus hardly a comfortable financial situation for low-wage injured workers, and this situation is unlikely to serve as an incentive to stay out of work (Glasmeier).

**Summary of All Results**

The data in this chapter expose the many challenges faced by Latino immigrants injured at work in accessing medical care, legal aid, workers’ compensation, and a sense of justice. This research highlights the precarious conditions many participants faced at work, but also how a generally agreeable work environment can crumble after an injury. Participants’ experiences show that rather than the result of isolated accidents, injuries were typically associated with and complicated by a variety of unsafe conditions, missing safety equipment, and lack of cooperation by employers. Workers rarely quickly decided to file a claim or report an injury as they feared losing their job or were unaware of their rights. Rather, they were more likely to wait while experiencing pain or deferring to employers’ propositions for delaying care or alternative compensation.

Other challenges illustrated some of the ways that neoliberal policies directly impacted workers seeking healthcare. Firstly, a neoliberal approach to healthcare includes allowing the business sector to increasingly infiltrate health care delivery in the U.S. (Rylko-Bauer and Farmer 2002). A heightened consideration of profit continually challenges the values of equity
and justice in healthcare. The ability to pay for care generally though insurance coverage has serious repercussions for an individual’s access to services (Rylko-Bauer and Farmer 2002). This also has repercussions in the workers’ compensation system based similar insurance schemes. In a market-based medical system, physicians worried about never being paid in cases where a workers’ compensation insurer denied a claim. This led to prohibitive preauthorization policies that forced workers to wait or forgo needed medical treatment. Another reason for delaying medical care was the high costs of emergency medical and specialty care. When participants hired lawyers, they often felt lawyers did not communicate clearly, and were left with many questions and frustrations about the case proceedings. Linguistic access was seen as an important problem by injured Latino workers as well as medical and legal professionals, and concern about the cost for translation and interpretation services was also a factor.

Results also highlight the role of these professionals as they mediate workers’ cases, and provide perspectives on how their biases and beliefs are involved in the process of relating to or evaluating claimants. In this sense, they emphasize the dangers of narratives of “undeservingness” and discourses about biomedical objectivity (Fassin and D'Halluin 2005; Willen 2012; Willen, et al. 2011). Facing social exclusion, immigrants are often “portrayed as unwanted, undesirable, and unworthy of services.” (Castañeda 2012: 830). Injured workers also encounter similar systematic narratives of being undeserving within the compensation system, and as a result they are treated with much suspicion (Beardwood, et al. 2005). Like in other systems evaluating human suffering, in the workers’ compensation system the use of medical testimony paradoxically objectifies and reifies the body while “systematically” doubting a victim’s word and narrative (Fassin and D'Halluin 2005: 598). Medical providers used a variety of methods to judge a claimants’ injuries, but in many cases, particularly those involving chronic
pain, subjective perceptions about a patient’s demeanor, behavior, and narrative played a large role in determining care and medical recommendations.

Additionally, doctors’ analyses are expected to separate truth from the body, and yet the process by which pain and other subjective symptoms are evaluated can instead supplant an injured worker’s lived experienced with a medical professional’s equally unique perspective (Fassin and D’Halluin 2005). Undocumented workers face additional challenges like being excluded from recent health reforms and programs like temporary disability insurance (TDI). Furthermore, even when initially receiving workers’ compensation benefits, participants faced difficulties with inconsistent coverage of procedures and medicines and after reaching maximum medical improvement (MMI) if their employer had no workers’ compensation insurance.
**Chapter Eight: Discussion**

During times of increasingly restrictive immigration policies and lax labor protections, analysis of work-related injuries or the imprints of power on the bodies of immigrant workers can help account for the casualties of our current political environment. (Fassin and D'Halluin 2005:597).

The workers’ compensation system encapsulates a microcosm of general politics influencing health, labor, and immigration. Thus, analyzing the experiences of injured Latino immigrant workers exposes another example of the hypervulnerability of uninsured and undocumented populations, those who are increasingly subjugated and separated from necessary services and benefits. Undocumented workers face the fear of being fired, but also fear uncertainty regarding whether laws or systems extend protections to them, all of which makes them more susceptible to exploitation. Once injured, their lack of access to health insurance leaves them with few options, and complicates their access to support like Temporary Disability Insurance (TDI) while they wait for approval from a workers’ compensation insurer. With reforms like the Patient Protection and Affordable Care Act explicitly excluding participation of undocumented people in state-run exchanges, and the restricted budgets of health centers that accept uninsured patients, undocumented persons are left with extremely few options (Quesada, et al. 2011). In Providence, when these workers are injured at work, they are subject to being blocked from attending physicians who fear never being paid by workers’ compensation insurers, and may be steered away from health centers where they have previously received care. If they do file a claim, research results indicate that workers continue to face barriers accessing
health care, and that retaliation is unfortunately not an unlikely consequence. The changing landscape of the labor market, with an increase in subcontracting, affects workers’ access to rights and legal protections, including coverage under workers’ compensation. While formal codified protections for undocumented workers and low-wage immigrant workers are important, results also demonstrate that they are only one portion of the efforts necessary to reduce abuse. Mechanisms that would allow codified protections to be implemented in tangible ways are needed, as are additional protection from retaliation specifically for workers’ compensation claims. The general scope and complexity of the problem also means that general immigration policy and health policy reform will have great effects on the efficacy and ethics of the workers’ compensation system. As long as no humane immigration reform is enacted, undocumented residents of the United States will continue to be more vulnerable to workplace abuses and barred from labor protections among other legal rights (Quesada, et al. 2011). These effects are exacerbated by the increased policing and legal persecution migrants face (Quesada 2011; Quesada, et al. 2011; Schenker, et al. 2014). The barriers many immigrants faced within the medical system also point to the weaknesses in the health system at large. Patients and doctors both were affected negatively by the market-driven system, and patients were frustrated by examinations that were too short, and by poor communication with their physicians. Physicians’ ideas about “culture” and biases relating to Latino patients discussed in this study connect to patterns of disparities along lines of gender and race in treatment of pain among minorities in other settings (Rahim-Williams, et al. 2012; Staton, et al. 2007; Weisse, et al. 2003). These issues also denote the need for changes in medical education and a diversified workforce in healthcare (Holmes 2012; Metzl and Hansen 2014).
A focus on the workers’ compensation system by researchers allows for an additional inspection of the biopolitical “administration of suffering bodies” (Fassin 2001:3; Foucault 1978 [1976]). Injured workers’ bodies and stories are evaluated in order to ascertain his or her credibility and subsequently their “deservingness” of compensation and medical attention (Horton 2004). Notably, the results of medical examination provide information about the severity of the injury, but also its “realness” and thus the integrity of an injured workers’ claim. An injury is deemed not real in part when physicians are unable to locate anatomical correlates for pain, but the difference between being diagnosed with a chronic pain syndrome, and being deemed a “faker” may have more to do with medical professionals’ intuition, biases and circumstantial observations. Because legal determinations, like whether an injury occurred because of horseplay, during travel to and from work, or as part of a true employer-employee relationship can hinge on witness claimant testimony, the preservation of a claimant’s character is extremely important in this medico-legal system. This research subsequently highlights the importance of incorporating and exploring the roles of the professionals who mediate access to compensation and care for vulnerable populations. Interviews with injured Latino immigrant workers elucidated how language, transportation, financial, and bureaucratic challenges significantly impeded their ability to access medical care and their right to compensation. Interviews with professionals show how they too deal with the consequences of the complex barriers experienced by patients and clients. Such complexity leads to frustration with the same convoluted fiscal or administrative processes within workers’ compensation. Doctors worried about being paid at all by insurance companies, and both doctors and lawyers struggled to communicate effectively with immigrant workers. At times all the additional layers of inconvenience led doctors or lawyers to dread interacting with Latino immigrant patients or
clients. This is important, as these professionals’ perspectives will clearly “affect the type and quality of care” and counsel provided (Holmes 2012: 874). Incorporating the structural barriers physicians and legal professionals face in working with vulnerable populations, and exploring their perceptions of their patients and clients allows for a better understanding of the barriers to redress and care for vulnerable populations.

Beardwood, et al. (2005:30) describe three trajectories for patients: one where patients recover quickly and are able to return to work, and face few other obstacles, if any at all; another where workers are “clearly disabled” and receive compensation; and a third where workers still “perceive themselves to be injured” but face barriers “returning to work and in obtaining recognition from the compensation system that they have a legitimate workplace injury.” This model helps illustrate a pattern of experiences by different injured workers in the compensation system, and shows what factors relate to a more complex and frustrating experience. Those whose injuries heal quickly or with little intervention, and those who have undeniably debilitating injuries that align with a biophysical etiology tend to have more straightforward engagement with the compensation system. This research shows that Latino immigrant workers, regardless of the severity of their injury, are quite susceptible to facing difficulties in Beardwood, et al.’s (2005) problematic and liminal third trajectory. Language barriers, cultural issues, and fear of retaliation or deportation complicate already contrived interactions between injured Latino immigrant workers and the workers’ compensation system. However the results of this research also highlight the importance and paucity of cooperation by other parties, especially employers. Taking a critical approach that considers the power differences between claimants and employers provides insights into how to make the workers’ compensation system more accessible and successful in meeting the needs of injured Latino immigrant workers.
Deservingness

The workers’ compensation system explicitly attempts to evaluate whether claimants merit compensation, and to what degree. What is further understated is how medical and scientific information blend and interact with evaluations of personal character, and the way in which various players come together to arrive at a decision. The court is often tasked with deciding whether claimants are lying or exaggerating, and not simply to adjudicate whether an injury or accident occurred in the course of work. The assumption that workers have incentives to malinger, to exaggerate or feign illness to avoid work, relies on depictions of comfort for those on benefits and malice towards previous employers that results from this research directly contradict. Mediating professionals’ heightened attention to the deservingness of a claim complicates a worker’s trajectory, which is often already riddled with barriers. Being subjected to multiple non-therapeutic medical evaluations and being repeatedly asked for details about their injury, workers are aware that their claims are under suspicion. Fear of being challenged and unfamiliarity with the system may lead workers to provide inadequate or incorrect information about their work (Beardwood, et al. 2005). If contradicting evidence or testimonies are introduced, a claimant’s credibility is subsequently questioned. Injured workers are also subject to preconceptions or biases that professionals and other arbitrators they encounter may hold (Beardwood, et al. 2005). Much research on workers’ compensation focuses on differences on utilization or delays in return to work (Beattie, et al. 2013; Kristman, et al. ; Meyer, et al. 1995; Swedlow, et al. 1992). This emphasis can obscure the mechanisms of the system, and the social context in which they happen. Typical findings include that workers go to the doctor less
frequently after they have settled their workers’ compensation case; that if compensated more, 
workers are less likely to return to work; and that physicians are more likely to prescribe more 
al. 1992). The conclusions from such studies often insinuate that workers abuse the system and 
depict physicians as avaricious.

Results from the current research, however, illustrate how such claims misrepresent the 
characteristics of injured workers and distort the mechanisms of the workers’ compensation 
system. For example, instead of rushing to contact a lawyer or leave work, many participants 
who were injured at work delayed seeking care and delayed reporting their injuries. For 
participants who eventually received benefits, the cut in pay was hardly comfortable and was not 
preferable to being able to return to work. Other participants, cut off from or never accessing 
medical benefits or weekly benefits, were forced to rely on loans from family and friends, or 
risked being evicted or not receiving medical care for injuries. At times, participants voiced 
sympathy for employers, despite unfavorable working conditions, opted to receive compensation 
directly from employers, and respected their pleas by not filing an official complaint. Survey 
participants’ experiences highlight how injured workers, especially when facing linguistic 
barriers, hold little control regarding their medical care. Mr. Leto, for example, voiced frustration 
with studies that seek to show that injured workers over-utilize healthcare.

Part of the reason for that is that while the claim is going in, the insurance company has 
conditioned their adjusters that the way you follow a claimant is through the medical 
treatment, through the reports you’re getting. So they encourage the employee, the first 
question they ask when you go to court on work injury, is when did they last see their 
doctor, how often are they seeing their doctor? Because they want to be able to see those 
medical reports, and that’s the only recitation of the person’s condition that the insurance 
company trusts. They don’t trust when a person comes into court and says ‘my neck 
hurts,’ they only want to see what the doctor says and what tests show. So they encourage 
the medical treatment while the claim is going on. So don’t talk to me about how the 
person didn’t treat as much after the injury was over, that’s because there was no
insurance company breathing down their neck, telling them go to your doctor because I want to see what your doctor says about your condition. So it works both ways. But I get sick of always hearing one side of it sometimes, from some of the studies that you see out there.

In his role as a lawyer, Mr. Leto has seen how systematic requirements are often not accounted for in critiques of the workers’ compensation system. The push for medical testimony provides an opportunity to have a third party constantly evaluate patient testimony and the “evidence” of the body. In fact, not being fastidious about attending appointments can be devastating to a seemingly straightforward workers’ compensation case. This is obvious in Jorge’s case. Never informed that the workers’ compensation insurance would reimburse or pay for transportation to medical appointments, Jorge stopped attending his frequent appointments because he was unable to secure a ride from friends. This allowed his insurer to argue that discontinuing care was a sign that his injury had healed, or that he no longer required treatment. And yet, high rates of utilization continue to be interpreted as evidence of the moral failings of injured workers or treating physicians. By providing a better understanding of the barriers and requisites that a claimants and physicians face, this research helps problematize conclusions about a claimant’s incentives and desire to indulge in unnecessary health care and treatments.

One of the troubling consequences of diffuse discourses of deservingness for Latino injured workers is the way that responses to additional barriers can mirror what professionals see as “suspicious” behavior. This includes delaying in filing a claim, delaying in seeking medical attention, or accessing legal aid before healthcare. The assumption is that more time between an injury and seeking care or filing a claim allows for an injury to have occurred elsewhere. Doctors interviewed for this study noted suspicion of workers who had seen other doctors already, or who had contacted a lawyer before seeking care assuming that this indicated more litigious and disingenuous motives. Holmes (2012:878) documented similar suspicions among doctors in
Washington state who spoke about migrant farmworkers “trying to work the system” by getting multiple opinions from different doctors. Lawyers interviewed for this study likewise voiced caution in taking on such case where an injured worker had previously hired another lawyer. Thus, after feeling diminished at a doctor or lawyer’s office, workers who attempt to seek out more sensitive care and counsel are perceived as searching for a more favorable decision. The same is the case when family members serve as interpreters. The results of this research contextualizes these actions as necessary adaptations to the real possibilities of being retaliated against at work, lack of information about workers’ compensation, fear of the high cost of emergency care, feeling humiliated or ignored due to insensitive or faulty attention from lawyers or doctors, and of course, denial of interpreting resources.

Discussions at Fuerza Laboral, whether relating to campaigns for humane immigration reform, licenses for undocumented persons, or labor rights, were often hampered by additional concerns about combatting discourses that depict economic migrants as opportunistic and even criminal. Leaders in the organization from diverging backgrounds shared an understanding of how Latino or Hispanic workers were stigmatized and criticized as generally “undeserving,” and constantly fought to rationalize or explain their own claims to fair working conditions and treatment (Chavez 2003; Quesada, et al. 2011; Willen 2007). Alternatively, this at times created divisions among leaders at Fuerza Laboral. While some wanted to emphasize a more universal advocacy for all immigrant rights regardless of any individuals’ law-abiding behavior, accusations of criminality targeting specific ethnic groups pushed some leaders to distance themselves from other immigrant subgroups that may have committed crimes and instead defend only those perceived as honest, hard workers. Thus, issues relating to workers’ compensation mirror and aggrandize an ongoing battle for immigrant deservingness (Horton 2004; Willen
Here, neoliberal discourses “intersect with local realities” to propagate further subdivision of deserving and undeserving populations (Horton 2004: 472). Research on the mechanics and barriers for workers seeking justice after work-related injuries helps operationalize one of the ways deservingness is brokered in immigrants’ and other vulnerable groups’ lives (Willen, et al. 2011). Injured immigrant workers, particularly the undocumented, are targeted by two layers of discourses of undeservingness, one through the virtue of being an immigrant, and another due to being an injured worker (Beardwood et al. 2005). The present study helps better understand the challenging experiences of those who face synergistic suspicion powered by multiple narratives of undeservingness.

*Professionals Mediating Injured Workers’ Experiences*

By including the voices of injured workers and medical professionals, this research project helps elucidate the role of professionals mediating injured workers’ experiences. Medical evaluation is one of the most obvious examples, as these assessments serve as an explicit form of control and are the basis for most decision-making within the court system. The reliance on medical evaluations in the court system, driven by a positivist understanding of injured or “suffering” bodies, in some ways abdicates the decision of whether a patient merits compensation to physicians (Fassin 2001:5). Through the primacy of medical evidence, a physician’s testimony replaces the injured person’s. Because injured workers are not trusted, due to suspicions generated by what they have to “gain” from filing a claim, a positivist evaluation of the body is preferred explicitly because it allows for context to be rendered irrelevant, until later reintroduced by legal advocates (Holmes 2014:115). The clinical gaze (Foucault (1994 [1963])), which transforms general maladies into anatomically correspondent lesions, is a cornerstone of the compensation decision-making process. Physicians working within workers’ compensation
thus are tasked with the objectification of the body. In fact, occupational medicine has long sought after additional ways to measure not only bodily injury, but also malingering. For example, the “spine ‘lie detector” gathered attention in the early 1990s. In this test, a patient was “strapped into a metal frame” and the “maximum force that the patient can achieve during the movement,” was measured, but the exam ultimately proved unable to provide ‘a specific pattern of measurements to correlate with submaximal effort” (Jayson 1992:8). These efforts specifically focus on quantifying pain, especially chronic pain, phenomena “poorly defined by biomedicine” (Good, et al. 1992:4). Anthropological study of chronic pain has exposed many of the weaknesses “in the way health professionals are trained and health care is ‘delivered’ in the United States” (Good et al. 1992:6-7). The puzzling nature of pain can shift focus from each individual’s unique condition or incentives, and instead can inspire reflection on “environmental hazards and power structures” as well as a critique of cultural categories (Good et al. 1992:6-7).

In contrast, study of Latino or Hispanics experience of pain has emphasized a culturally unique understanding of the mind-body duality that incorporates somatization of emotional issues as physical complaints (Dualba and Scott 1993). Such approaches constitute a form of exotification that precludes critical analysis of differences in experiences of pain. In the present study, physicians self-consciously explained similar ideas about Latino patients perceiving, expressing, or feeling more pain than Anglo patients, and perceived an overrepresentation of Hispanic patients with chronic pain syndromes. Previous anthropological perspectives on chronic pain have shown that when patients are already experiencing delegitimization, in this context through the questioning or denial of their claim by insurers and employers, physicians disconfirming the physiological markers of their pain can intensify feelings of diminishment (Good, et al. 1992). This is further amplified within the workers’ compensation system, where
physicians are explicitly alert to signs of malingering or exaggeration. These interactions play a role in pressing patients to dramatize their symptoms and emphasize their suffering, and unaddressed language barriers aggrandize these challenges (Kleinman 1997:133). This was likely the case in the frustrating interactions Dr. Walton and Dr. Taylor described, with patients insistently mentioning their pain and not providing information about other aspects of their injury.

For injured Latino workers, issues of racial and ethnic bias compound these interactions. Differences in treatment and quality of care have been widely documented for minority populations (Feagin and Bennefield 2014; Johnson, et al. 2004; Meghani, et al. 2012) and often noted in pain assessment and management. Hispanic patients with serious fractures have also been documented to wait longer to receive pain medication than Caucasian patients with comparable injuries (Council on Graduate Medical Education 2005). Health professionals routinely underestimate and provide overly conservative treatment for reports of pain in black and Latino patients (Anderson, et al. 2009; Burgess, et al. 2013; Cintron and Morrison 2006; Staton, et al. 2007). Having been taken in an ambulance to the emergency room after falling down a staircase, Carlos’ experiences illustrate the consequences of these actions. Dismissed from the hospital in a few hours, he was left to recover by himself at home, where he was much more likely to fall and reinjure his knees as he struggled to complete simple tasks like going to the bathroom. Such underestimation of pain and extent of injury confirms patients’ worries that they must validate their pain and suffering and could contribute to the characteristics that physicians I interviewed attributed to Latino or Hispanic populations. Additionally, physicians’ observations about Latino patients perceiving pain differently falls into a long tradition of “othering” pain experiences of immigrants, despite problematic methodologies for making such
assessments. Medical literature has historically characterized migrant workers as somatizers or hypochondriacs and this has no doubt impacted the care they have received. Somatoform disorders include the distress experienced as physical symptoms that often do not overlap with biomedical etiologies. Medical literature has also noted “migrants’ uncontrolled, hysterical, and dramatic expressions of pain or discomfort” (Castañeda 2012: 832). In Germany, for example, Turkish and Italian guestworkers’ expressions of pain were institutionalized as “Mediterranean Syndrome” or “mama mia syndrome” (Castañeda 2012; Ernst 2000; Zimmermann 2000). Thus, a cross-cultural review of academic literature in migrant health documents perceptions of immigrants like those discussed by doctors in this study across the world. The constant in these observations is not a specific immigrant group or host country, but instead immigrants’ pain being perceived differently regardless of the cultural context. The ubiquity of this perception seems to indicates more about how health care systems and personnel react to and treat immigrants, than generalizable information about Latinos or other immigrant groups.

**Side Effects of Market-Based Medicine**

The Rhode Island workers’ compensation system has some more progressive elements that attempt to balance multiple interests. One such feature is the decision to keep medical reimbursement rates competitive enough to encourage a wider range of physicians to participate in workers’ compensation. This is a necessary within a market-based medical system, as low reimbursement produces many problems in other states, like Massachusetts, were rates are below those for Medicare (Lipton, et al. 2010). However, delays in payment by insurers or the possibility of having a claim be denied has led to health facilities requiring preauthorization, and for primary health centers to steer patients injured at work to employer specified centers. Doctors worried they might never receive compensation at all, as insurers continue to submit payments.
Yet such policies are detrimental to the ethics of the workers’ compensation system notably by delaying care for injured employees. The current preauthorization policies put in place by health facilities, as Mr. Leto describes, “what they do is hold treatment hostage and the patient hostage to getting the approval of the insurance company before they will do it.” He goes on to say that such adjustments may require medical professionals to be flexible and accept the possibility of slightly incomplete reimbursement. These policies most likely adversely affect most of the most vulnerable claimants, the undocumented or uninsured, who are left with almost no alternative routes to care. Despite other encouraging characteristics of the Rhode Island workers’ compensation, attention must be paid to how market-based medical care excludes vulnerable workers, and how these predatory effects can be mitigated within the system by guaranteeing injured workers proper medical attention, even when their cases are yet decided.

**Claims as a Catalyst**

The workers’ compensation system functions not only to provide redress for injuries, but also to “provide a safety incentive for employers” (Boden, et al. 2001; Dembe 2001). If employers maintain a safe work environment, and provide proper equipment and training, they are more likely to reduce the incidence of injuries and subsequent hikes in insurance premiums or sanctions for OSHA violations. But when workers are deterred from filing claims, or their claims are quickly dismissed, this function breaks down, allowing employers greater degrees of impunity. The importance of addressing barriers for immigrant and minority workers trying to file claims and have them respected through the legal system cannot be understated. In this research, injured workers noted how despite their claims being contested, they heard from co-workers that more safety equipment was now being offered by their previous employer. Working in industrial recycling, Jorge felt that safety procedures and precautions were commonly violated
at his workplace. Some employees operated machinery with little training or without a license, and Hispanic workers were often denied access to or charged for basic safety equipment like gloves and masks. He noted that his employer had made changes after he filed his claim for his arm injury, “But they’re doing this after me. Right now they’re giving out gloves, and they gave out masks with filters at both sides.” Another worker reported having more training and more supervision from insurance company representatives after they filed their claim. These examples show how encouraging workers to file claims, and the work Fuerza Laboral completes in supporting them to do so is extremely important to the preventative functions of the workers’ compensation system as a whole. As few who have yet to be injured are willing to jeopardize their employment for the risk of disability, orchestrating direct action around workplace injuries complex. Yet, understanding the role of claims-making highlights the importance of Fuerza Laboral’s efforts and their work in collaboration with the workers’ compensation court officials. Filing a claim can serve as a catalyst for better work conditions, but also helps workers regain dignity during an otherwise victimizing and objectifying process. Jasmin also described the effects she her claim would have,

I know that even if I don’t win this case, I know that the next year, they’re going to try to have more safety, and even if the other people don’t deserve it, even if I don’t know them, they’re going to have a better workplace…if I received money it might help me in the short-term…but that ends, dignity, the satisfaction of being human, that never ends.

**Retaliation**

Rhode Island follows the employment-at-will doctrine, and there are no statutes regarding wrongful discharge beyond general nondiscriminatory provisions (Title VII of the 1964 Civil Rights Act), and whistleblower protection under General Law 28-50-1 (Muhl 2001). Workers’ compensation law does include a “right to reinstatement,” which allows workers to return to their former position or another available position with the same employer. However, the right
reinstatement is only available to workers under certain conditions. The results of this research signify that this uneven patchwork of rights is not enough to truly protect claimants from retaliation in the form of being fired, or harassed when returning to work. As of now, the system relies on the same employers who often were not able to prevent an accident, and who did little to avoid dangerous working conditions, to honor the right to reinstatement. This is also the case with “light duty” work, where injured employees return to work to find that few accommodations are actually provided, often aggravating existing injuries. In his interview, Judge Ragan discussed how after a case is decided, the workers’ compensation court is not involved in or consulted about issues relating to retaliation for filing claims. Many other states employ exceptions to at-will employment regarding workers’ compensation by providing specific protections, specifying that there should not be retaliation or discrimination against an employee for filing a claim (Muhl 2001) with some variations on who has the burden of proof, either employees or shifting burdens between employees and employers (Altman et al. 2012). Strengthened legal protections, and a system for workers to report cases of retaliation would allow injured workers some recourse after being fired for taking time off work to see a doctor, reporting an injury, or asking for appropriate accommodations post-injury.
Chapter Nine: Conclusions and Recommendations

Even after facing dangerous conditions, hostile supervisors, and discrimination, when Latino workers are injured at work they often felt, as Sandra summarized, that “one has to fight everything” in search for justice, redress, and their right to compensation. From feeling stigmatized in seeking care and excluded from important mechanisms of support during trial, to having to hound lawyers for responses to their questions and calls, Latino workers are at a disadvantage due to their compromised position in society and in labor hierarchies, which complicates their ability to exercise their rights. The workers’ compensation system in Rhode Island counts on dedicated professionals who believe in making the system work for everyone and have initiated outreach and education with immigrant communities heavily affected by workplace injuries. Groups like Fuerza Laboral have actively engaged with these efforts, and this study provides an opportunity for officials, like those serving on the court’s Advisory Board, and community professionals, such as medical staff and legal representatives, to learn about the gaps and faults of the system through analysis of workers’ experiences. While legal protections such as a right to workers’ compensation for undocumented workers provide useful tools for redress, there is also a need for additional codified protections from retaliation. Moreover, it is also important to consider how to make these rights accessible in the lived experiences of immigrants.

Underreporting is a problem, and these research results indicate that workers generally try to avoid filing a claim or reporting an injury if possible. Judge Ragan concurred, noting that the immigrant and non-English speaking community members are “intimidated to not file for their benefits, and not making their complaints, and not calling OSHA, and they’re the ones who are
often the most at risk.” They also attempt to put up with their pain for as long as possible, seek healthcare at charity clinics, and often cooperate with employers following injuries. Participants reported having sustained previous injuries, and noted that others at their workplace had been injured and had not reported their injuries. Fear of being unemployed, concerns about cost, and lack of information provided by employers affected workers’ claims-making and health-seeking behavior. However, the current research, by focusing on workers who did eventually report injuries and file claims, highlights how when vulnerable workers are not silent, they can be still be ignored or silenced by employers or insurers, even when exercising their legal rights. These data emphasize the need for disenfranchised injured workers who have gone through workers’ compensation to be included in any future initiatives or discussions aimed at improving or reforming the system. Any conversation must also include the voices of immigrant workers, who are not only more likely to be injured on the job, but are also more likely to face barriers accessing redress and compensation. While other representatives like union leaders and attorneys may be sympathetic and may have gained insight in the challenges faced by injured immigrant workers, these study results indicate that the professionals mediating the compensation system have different perspectives on key issues than the workers themselves. To prevent workers’ testimony from being further displaced by expert testimony, efforts moving forward should make sure to include injured workers’ voices.

Many professionals emphasized the importance of educating workers about their rights and system procedures, as Dr. Taylor opined, “I think it’s mostly education, all the way through, on what’s good and what’s bad.” Legal professionals also emphasized the importance of education and information in such cases, with one arguing, “Knowledge is power. I feel that’s a mantra that I live by, which is why I try to arm my clients, with as much knowledge [as I can].”
Considering the paucity of accurate information about workers’ rights and the proceedings of the workers’ compensation system, there is no doubt that initiatives focused on education are important. One of the goals of such educational programs is to encourage workers to file claims and seek care, to inform them that they do not face dangers, such as deportation for filing a claim, and to notify them that workers’ compensation insurance will provide payment for healthcare. Results indicated that workers who exerted their right to compensation have contributed to some increase in safety equipment distribution and even in safety courses, but without ensuring that workers who file claims or report injuries can participate fairly within the workers’ compensation system, those who act up will be left to act as martyrs.

As such, a workers’ compensation court system provides an interesting case study in the performativity of victimhood, as a successful case depends on the passive virtuousness of injured employees and yet the act of filing a claim itself contradicts such a role (Ticktin 2011). Lázaro’s experience is indicative of these dilemmas. At work, he was routinely asked to take injured workers to an occupation health center by his employer, and was always instructed to not let anyone know the injury had occurred at work. When he accompanied Jorge to the doctor, the clinic administrator noticed their boots and clothing and told them not to be afraid to say that Jorge’s accident had occurred at work. Like Jorge, Lázaro was soon fired, and he suspects this was related to his helping his co-worker. He is currently attempting to seek legal representation for a retaliation case. Lázaro also sought to report the hazardous working conditions at his workplace to OSHA. He spoke to a representative twice, and told him about all the problems at his previous employer—the ripped gloves, the lack of licensing and training, and the generally dangerous environment. The representative communicated at times without an interpreter despite his knowing little Spanish and Lázaro’s limited English skills. Lázaro understood that the OSHA
representative told him that because he was recently fired, he, the representative, had no way of knowing whether Lázaro was only filing a complaint because he was upset at being fired, and directed him circuitously to Fuerza Laboral. Lázaro was left frustrated when it seemed that the OSHA representative did not take his complaints seriously, and such situations have led to a loss of confidence with OSHA for him and other survey participants. Experiences of workers who have spoken up and were met with resistance from employers, medical professionals, lawyers, and insurers help “shift back the burden of workplace safety to employers and agencies meant to regulate them” instead of solely emphasizing the claimant’s responsibility (Cole and Brown 1996; Flynn and Eggerth 2014:385). A system of redress for occupational injuries would ideally take into account the social context of an accident, such as the type of employment, language barriers, and education disparities. Further considerations on how to make a system better would also benefit from a critical perspective that considers differential power between participants (MacEachen, et al. 2010). Central to this is recognizing that retaliation is a real consequence of filing claims and reporting injuries, not only an unsubstantiated fear, meaning that undocumented and Latino immigrant workers require tangible protections from retaliation. The first step in this process would be the development of legislation that would explicitly make it illegal to retaliate against or fire a worker who was injured or filed a compensation claim. As recent efforts around the country pushing for wage theft prevention legislation have shown, more significant protections would be needed to curb the variety of potential avenues for retaliation against employees post-injury (Gleeson 2012a). While individuals “have a role to play in maintaining a safe workplace, it is often the attitudes and policies of the employer that have a greater impact on how work is performed” (Flynn and Eggerth 2014:388; Neal and Griffin 2004). Similarly, after an injury, employees have many duties to uphold, but exclusionary policies by insurers and
employers and implicit racial bias throughout the process are likely to have a greater effect on the outcome of a compensation case.

Many problems within the workers’ compensation system are intensified consequences of deficiencies in the healthcare system and immigration regime. Thus, fully addressing these problems would require far-reaching, humane immigration reform, living wage ordinances, and near upheaval of our healthcare system. However, an increased sensitivity to the challenges faced by injured workers on the part of legislators and officials provides the workers’ compensation system an opportunity to break an exploitative cycle. Otherwise, if workers from society’s most vulnerable groups are less able to access justice after work-related injuries, employers can continue to take advantage of these workers with few consequences.

The negotiations medical and legal professionals make on behalf of patients and their employers are complex and important factors in a compensation case. Built upon a market-based medical system, the workers’ compensation system activates physicians’ concerns about non-payment, and thus must introduce additional mechanisms to curb the ubiquity of preauthorization requirements in clinics and medical practice. In acknowledgement of well-documented bias in medical treatment and diagnosis for patients of color, efforts could also be made to balance the gradients of power between physicians’ evaluations and workers’ testimony. Additionally, reliable language access needs to be reframed as essential to medical and legal practice in diverse metropolitan areas, especially within the workers’ compensation system, where the quality and ‘reliability’ of interpreters have additional repercussions in court. Doctors interviewed for this study worked in different settings, including a community health center, three private practices, and a hospital. The chiropractor’s office, with more limited resources than large hospital-affiliated practices, nevertheless employed interpreters in three languages. Language access is
complex, but as a bare minimum, physicians should consider training bilingual employees and complementing these limited efforts with telephonic interpretation with certified interpreters. Having children as young as eight years old interpreting should not be seen merely as a lamentable reality, as both orthopedic surgeons reported in interviews, but rather as something that could be altogether avoided at specialty practices. Additionally, at least one survey participant reported he or she was not provided with interpretation services at Memorial, Miriam, and Rhode Island Hospitals. This is especially discouraging, as in Rhode Island (General Laws § 23-17-54), every hospital is required to do so,

as a condition of initial or continued licensure, a qualified interpreter, if an appropriate bilingual clinician is not available to translate, in connection with all services provided to every non-English speaker who is a patient or seeks appropriate care and treatment and is not accompanied or represented by an appropriate qualified interpreter or a qualified sign language interpreter who has attained at least sixteen years of age (Chen, et al. 2007:364).

Lawyers interviewed had begun to integrate language access by translating important forms, for example, but survey participants still reported hurried and unclear communication. Like workshops offered for workers by the education unit of the court, trainings for attorneys could provide opportunities for injured workers to speak directly to legal representatives about how insensitivity and miscommunications have affected their cases, and their lives.

In light of these conclusions, several potential foci of action and effort exist for Fuerza Laboral’s Injured Workers Committee. Regarding issues with doctors and attorneys, ongoing use of the survey tool as an intake tool could help identify a network of more respectful and sensitive medical providers and legal professionals. If more problems continue to be reported, Fuerza Laboral could also focus attention and efforts on deficiencies at individual medical facilities such as Concentra, which treated the largest number of survey participants (n= 7), and where some workers reported feeling disrespected and were not provided with interpreting services.
Worker leaders can also continue to share their testimonies and the results of this research with representatives from the Workers’ Compensation Court, such as the Advisory Council, and can call for collaboration in developing mechanisms that could curb required insurance preauthorization, which denies injured employees appropriate health care, and for legal instruments that could provide more options for workers who are retaliated against after filing a claim. Generally, Fuerza Laboral’s membership and years of experience with affected communities could prove advantageous in setting up task forces that could document and respond to injured workers’ negative experiences with medical and legal professionals.

Exploration of the challenges faced by injured workers, such as the barriers to filing a claim, highlight the need for flexibility in statutes of limitation for filing or reporting an accident. Understanding the additional barriers in occupational retraining and rehabilitation would mean accommodating the long-term timeline for learning a new language in addition to a new technical skill for patients who are permanently disabled or have reached maximum medical capacity. Extending retraining opportunities to workers whose claims were denied could help those affected by legal loopholes or dishonest employers avoid financial ruin and continue to drive economic growth. Moreover, efforts must be made to secure the Uninsured Employers Fund and to pay for injured workers’ benefits and medical expenses in cases where employers did not have workers’ compensation insurance. The architects of the current system included the creation of this fund, but it is needless to say that in order to for it provide tangible support, adaptations must be developed so that the fund can function appropriately. In order for any legislative changes stemming from these results and conclusions to take place, worker leaders and Fuerza will need respectful input and dedicated cooperation from legal specialists and
experienced members of the medical community. Thus, coalition building will continue to be of the utmost importance.

Likewise, results indicate that alongside support for integrating injured worker feedback and voices into policies, Fuerza Laboral should continue its other initiatives, as there is a great ongoing need for exposure to workers’ rights and information about the workers’ compensation system within the Latino immigrant community. Considering increases in subcontracting and general fragmentation of responsibility in many labor sectors, alternative models of dissemination are likely to continue to have great impact (Flynn and Eggerth 2014). Yet, if organizations like Fuerza Laboral are to be tasked with providing information traditionally dispersed by employers, it is also important to note the need for financial and other support for such community organizations. It is difficult to fundraise for injured worker organizing as claimants are persistently demonized in popularly held narratives, and most people assume that such issues are already taken care of by the court system. This research project has helped better elucidate some of the ways this system can be strengthened, the challenges faced by Latino immigrants injured at work, and the important roles worker centers play in contemporary society. In agriculture, the Coalition of Immokalee Workers (CIW) has developed worker-led reporting of labor abuses in the fields, and such a model could serve as a basis for some similar adaptations to the reporting of discrimination throughout workers’ trajectories post-injury (Asbed and Sellers 2013).

Without a doubt, more quantitative and qualitative research is needed to acknowledge and understand the true social, political, and personal costs of workplace injury in the United States, especially for immigrant communities. Future anthropological research would contribute to efforts aimed at tallying the deaths and injuries manufactured and concealed by the modern,
neoliberal political and economic climate. More information about immigrants’ workplace injuries would provide insight into general consequences of migration and help guide innovative and inclusive approaches to occupational well-being. The Injured Worker Committee has worked to build a movement and gather attention to the struggles they have witnessed. This research study allowed for a systematic documentation of the problems faced by immigrant workers and helped generate momentum for the group by organizing and focusing Committee activities. This project also demonstrates how engaged medical anthropologists can contribute more immediately to the efforts of community-based groups, and how they can invigorate grassroots approaches to addressing both unjust labor practices and their subsequent impact on the health of individuals and communities.
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Weisse, Carol S., Paul C. Sorum, and Rachel E. Dominguez

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2011 Take a stand commentary: How Can Medical Anthropologists Contribute to Contemporary Conversations on "Illegal" Im/migration and Health? Medical Anthropology Quarterly 25(3):331-56.

Zimmermann, Emil

Ziner, Karen Lee
Appendix: IRB Letter of Approval

6/3/2014

Carla Castillo
USF Department of Anthropology
4202 E. Fowler Ave.
Tampa, FL 33620

RE: Expedited Approval for Initial Review
IRB#: Pro00017464
Title: Latino Immigrant Workers’ Search for Justice After Occupational Illness or Injury


Dear Ms. Castillo:

On 6/3/2014, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents outlined below.

Approved Item(s):
Protocol Document(s):
Castillo IRB Protocol_v2.05-30-14.docx

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the
requirement for the investigator to obtain a signed consent form for some or all subjects if it
finds either: (1) That the only record linking the subject and the research would be the consent
document and the principal risk would be potential harm resulting from a breach of
confidentiality. Each subject will be asked whether the subject wants documentation linking the
subject with the research, and the subject’s wishes will govern; or (2) That the research presents
no more than minimal risk of harm to subjects and involves no procedures for which written
consent is normally required outside of the research context.

As the principal investigator of this study, it is your responsibility to conduct this study in
accordance with IRB policies and procedures and as approved by the IRB. Any changes to the
approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University
of South Florida and your continued commitment to human research protections. If you have
any questions regarding this matter, please call 813-974-5638.

Sincerely,

[Signature]

John Schinka, Ph.D., Chairperson
USF Institutional Review Board