Crossing Borders with Information and Resources for the Treatment of Diabetes

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Abstract

This paper describes transnational articulations experienced in the everyday lives of working class Mexican Americans who attempt to combine information and resources to treat their diabetes by crossing—and in some cases, not crossing—the border between the United States and Mexico. The persons who were interviewed cross medical, political, and cultural boundaries in order to obtain medical information and remedies. This paper also illustrates that the “border region” can be seen as extending from San Antonio to Monterrey.

Resumen

Este documento describe las articulaciones transnacionales que experimentan cotidianamente los trabajadores Mexico-Americanos que tratan de combinar información y recursos para tratar su diabetes al cruzar—and en algunos casos no cruzar—the frontera entre México y los Estados Unidos. Las personas que fueron entrevistadas interrelacionan el enfoque médico, el político y el cultural para obtener información médica y remedios. Este documento también muestra que “la región fronteriza” puede ser entendida como una extensión desde San Antonio hasta Monterrey.

Introduction

This paper discusses the transnational articulations experienced in the everyday lives of working class Mexican Americans who were attempting to combine information and resources to treat their diabetes

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2 I am grateful to Kathleen Murphy for reading earlier drafts of this paper and her input on the use of the term “transnational”. Earlier versions were presented at the 1996 Society for Applied Anthropology Annual Meetings in Baltimore, MD (theme: Global-Local Articulations) as part of a planned session entitled: “Listening to the Voices: U.S. and Mexican Perspectives”, organized by Kathleen M. Murphy and De Ann Pendry; and at a research symposium on The Survival of Families in Poverty in the United States/Mexico Border Region, sponsored by The School of Social Work, The University of Texas at Austin and the Facultad de Trabajo Social, Universidad Autónoma de Nuevo León, February 19-20, 1998, in Austin, TX.
by crossing—and in some cases, not crossing—the border between
the United States and Mexico. This paper will illustrate that the “bor-
der region” can be seen as extending from San Antonio to Monterrey,
if not even further, say from Rafford, Illinois to Allende, Mexico,
which are “just” north and a little south of Piedras Negras and Eagle
Pass.

According to Gramsci (1971), “common sense” (i.e., the everyday
knowledge of the working class) is often fragmented and contradic-
tory. Likewise, several authors use the metaphor of fragmentation
to describe postmodern life, particularly with respect to the produc-
tion and consumption of information (e.g., Harvey 1989, Jameson 1991,
Limón 1994). These approaches suggest that there are fragments and
contradictions in the everyday lives and discourses which constitute
the knowledge of people who are subordinated in terms of class, race/
etnicity and/or gender. The working class Mexican American women
and men, who were the subjects of our study, experienced both the
(hegemonic) biomedical system and its alternatives in ways that of-
ten were very fragmented—a ten-minute doctor’s appointment here,
and an overheard conversation in the waiting room there. Sometimes
they also had to sort through contradictory advice from different bi-
omedical practitioners. Furthermore, they made treatment decisions
in the context of the complex and often contradictory needs and desires
of their daily lives. For example, due to his relative poverty, Gilbert
Suárez had to choose between buying his medications or buying his
children Christmas gifts. He bought the gifts.

And yet, just as Anzaldúa (1987) suggests that mestiza identity rep-
resents an attempt to work out a synthesis of various contradictory
and ambiguous elements, I would argue that the Mexican Americans we
interviewed were attempting to put together what for them constituted
a relatively coherent approach to treating the illness known as Type
II or adult onset diabetes. They did this by weaving together (some-
times contradictory) fragments of information and resources from
multiple sources with the other priorities and concerns of their daily
lives. For several of the interviewees, the processes of obtaining in-
formation and resources sometimes entailed crossing national, cultural,
and/or medical borders. This paper focuses on those border crossings,
with attention to how people obtain, use, and assess medical infor-
mation and resources from the biomedical system in Mexico and from
sources of alternative medical knowledge, such as curanderismo and
herbal home remedies. Essentially this paper explores how the people
we interviewed used options other than the biomedical clinic in San
Antonio at which they all were receiving services.

The analysis is based on structured open-ended interviews conducted
in 1993 and 1994 with thirty-five Mexican Americans diagnosed with
Type II diabetes who were receiving medical services at a county clinic
in San Antonio, Texas. The interviews were usually about two to four
hours long, with some as long as eight hours. The research was funded
by part of a larger National Institute of Health grant administered by
the Mexican American Effectiveness in Medical Treatment Research
Center (MERCE), the University of Texas Health Sciences Center
in San Antonio, and the University of Texas at Austin. The principal
investigators were Jacqueline Pugh, Laura Lein, and Linda Hunt. I
conducted most of the interviews, with some help towards the end of
the project from Miguel Valenzuela, a graduate student at the Univer-
sity of Texas at San Antonio. The interviews focused on the history
of the course of the illness and beliefs about its causes. Throughout
the interviews, we continually asked why a particular decision was
made, with whom the person had talked, and how he or she reacted to

3 Gramsci uses the term “common sense” as in common among many people, which
he contrasts with “good sense” and “philosophy.”

4 All three authors use the term “postmodern”, but ultimately specify that they are
discussing cultural life within a late capitalist economic system.

5 For example, the nutritionist told Daniel Celestín that he should eat half a banana
during a meal. Daniel then asked his internal medicine doctor about this, and she said
it was OK to eat a whole one, so he decided to go with the doctor’s advice. (Daniel’s
name, as well as all the others I use in this paper, are pseudonyms.) Rebeca Rocha
had to balance the recommendation to do regular exercise for her diabetes by her in-
ternal medicine doctor, with a recommendation from the podiatrist to cut back on
walking, while her foot was healing from an injury. Dealing with co-morbidities is
another source of contradictions for several of the interviewees.

6 My dissertation (in progress), Control, Compliance, and Common Sense: Power
Relations in Diabetes Care for Mexican Americans, examines in more detail their
interactions with the biomedical system in San Antonio and their assessments of that
care.

7 The interviews were conducted in English, Spanish, or English and Spanish. Twelve
interviews were done during the pilot phase of the research. Some of those interviews
were taped and for some, I took notes. The interview schedule was revised and the
subsequent twenty-three interviews were all taped and transcribed.

8 Jacqueline Pugh is an internal medicine doctor who specializes in diabetes; Laura
Lein is an anthropologist specializing in issues related to persistent poverty, house-
hold budgets, women, and children; and Linda Hunt is a medical anthropologist who
had conducted research on cancer in Mexico (among other projects).
that information. We also asked questions about sources of information about diabetes.

Of the thirty-five people we interviewed, the seven born in Mexico—all of whom had migrated to the United States as young adults—had more contacts with the biomedical system in Mexico than the twenty-eight born in Texas. These contacts occurred primarily through their extended families who were still living in Mexico. To explore these connections, the first section of this paper discusses the life and illness histories of the Mexican migrants in detail. This is followed by a brief comparison with the interviewees born in Texas, who had almost no contacts with the biomedical system in Mexico. Throughout the paper, I will refer to the interviewees who migrated from Mexico as *mexicanos* and to the interviewees born in Texas as *tejanos*.

In the first draft of this paper, I referred to the *mexicanos* as "the Mexican-born interviewees" and to the *tejanos* as the "the Texas-born interviewees". In this draft, I occasionally use the English-language terms.

Originally I chose to use the fairly cumbersome English-language terms in order to highlight the notion that they were analytical categories that I had constructed for the purposes of this paper. By repeatedly using the "interviewees", I wanted to stress the specificity and constructedness of the ethnographic data itself. In a way, I was also side-stepping having to choose between the many different "ethnic" terms that people used to identify themselves in the context of the interview, not to mention how they might identify themselves in other social contexts. I still regard these issues as important, but in this draft, I chose to rename my constructed categories.

One advantage of changing the terms to *mexicanos* and *tejanos* is to privilege Spanish-language terms. In addition, after reconsidering the analysis, birthplace is salient, but what is more important is that all "the Mexican-born interviewees" migrated to the United States as young adults, and even more important, that some or all of their birth families remained in Mexico. These are the family members through which they had direct or indirect contacts with the biomedical system in Mexico. In our sample of thirty-five people, we did not happen to have any interviewees who were born in Mexico, but migrated as a child with their entire family (although this was the case for some of the parents and/or grandparents of the "Texas-born interviewees"). I believe that such a "Mexican-born" person would be more like the "Texas-born interviewees", in that his or her parents and siblings with diabetes (also having migrated) would have been interacting primarily with practitioners in the United States (rather than in Mexico).

The term *mexicanos* then is intended to retain the sense of identification with Mexico, without over-emphasizing birthplace as the essentialized characteristic. In fact, the seven people born in Mexico tended to use the term *mexicano/a* to describe themselves when asked about their "ethnicity". However, one problem with using this term the way I am is that several of the Texas-born interviewees, particularly when speaking Spanish, also use this term to describe themselves. Furthermore, my choice of *tejano* is arbitrary since not that many of the people I interviewed used or even discussed that term.

The final section outlines how the *mexicanos* and *tejanos* obtained alternative medical knowledge and remedies locally and/or in Mexico. Diet, exercise and medications are all crucial in diabetes care, however the analysis will focus on medications and herbal remedies.

This paper examines transnational articulations in the lives and medical practices of people diagnosed with diabetes. However, transnational articulations also occur in the everyday practices of the medical practitioners who treat these people. For example, while I was doing the field research in San Antonio, one of the Diabetes Education nurses (Mexican American, raised in South Texas, and fluent in Spanish) went to Monterrey, Mexico to a private clinic owned by consortium of industries to give a lecture on diabetes care to over 300 patients and a number of practitioners. Later, I took a brief trip to Monterrey and visited several clinics. There I talked with an endocrinologist working at a Seguro Social clinic, who had worked in Houston on a research project interviewing Mexican Americans diagnosed with Type II diabetes. The many transnational articulations within biomedical practices go beyond the scope of this paper, but these two examples illustrate that practitioners, as well as patients, cross the border between Mexico and the United States and exchange information and knowledge about diabetes care.

Transnational Articulations in the Daily Lives of the Mexicanos and their Interactions with the Biomedical System in Mexico

Of the thirty-five people interviewed, seven were originally born in Mexico, three men and four women, ranging in age from 43 to 63. All seven are either long-term residents of or have had long-term connections with the United States, in most cases, for twenty years or more. At the same time, most of them maintained contacts with their families (especially parents and siblings) in Mexico, and these transnational social networks played a role in their approaches to diabetes treatment. As one might expect, their contacts with the biomedical system in Mexico were more extensive than for the Texan-born interviewees.

The transnational articulations at the level of biomedical practice and education would be a fascinating topic for future research. I would suggest that the knowledge exchanged by practitioners is not limited to formal or systematized biomedical knowledge. Practitioners, as well as patients, have common sense knowledge which also affects their approaches to diabetes care. Foucault (1980:82), for example, notes that doctors and nurses, as well as patients, have forms of local or "subjugated knowledge".
Lupe Tamayo’s story is perhaps exceptional, but it illustrates how complex the transnational articulations can be in the life of one individual. The articulations occur within her work history and social relationships, which in turn affected her approach to diabetes treatment. In her narrative, Lupe emphasizes her own poverty as the primary factor that motivated her to obtain her diabetes medications through her mother in Mexico. Although Lupe’s husband is Puerto Rican and both of her children are married to African Americans, Lupe identifies strongly as a mexicana and has maintained contacts with her family in Mexico.

Lupe (age 54) was born in Monterrey, Mexico. Her mother and her mother’s parents were from a small town in Nuevo León. Her father was born in Monterrey, while his parents were from San Luis Potosí. Lupe got a sixth grade education, and then started sweeping streets and worked in several factories before getting a job in a General Electric light bulb factory, where she worked for eleven years. She says that she worked like a “burrito”, but liked the work and the responsibility. She noted that since it was an American company, she got good benefits and good pay, which was paid by the hour rather than by the day. During that time, she took a vacation to visit her sister in San Antonio. Lupe’s sister originally had migrated to Houston illegally but by that time was married and a legal resident. During her visit, Lupe met a friend of her brother-in-law, a Puerto Rican man (with family in Puerto Rico and New York) and a Viet Nam veteran, about to be discharged from the military. A year later they were married, he filled out the paper work for her to migrate legally, and she moved to San Antonio. Lupe’s husband began working for the State Highway Department. In 1983, he was struck with a respiratory illness that got worse over time. By 1991, he had to retire early and go on disability.

Lupe and her husband have a son, age 24, and a daughter, age 23. Lupe worked inside the home until the children were about 10 or 12. Then she worked (for income) at a dry cleaners ironing clothes; later she took in her husband’s co-workers laundry and did child-care in her home; and then she worked for several years cleaning offices and/or houses. She stopped working around 1991, when her husband became very ill. Lupe divorced her husband when she discovered that he was planning to cut her and the children out of his will, but they still live in the same house (in separate bedrooms) and she still takes care of him.

Both children are married to African Americans. The daughter has no children yet, and the son (now living in California) has a 1 1/2 year-old daughter by his wife, and a 3 year-old son by a previous relationship (also an African American woman). Lupe and her husband frequently take care of their grandson. They live on the West Side of San Antonio, which overall is regarded as the “Mexican American” side of town, however they live in a small neighborhood that traditionally has had a number of African American residents. In fact, most of their neighbors are African American.

Despite these cross-cultural connections, Lupe regards herself as “mexicana hasta las cachas”. Her two best friends are mexicanas, and she would like to return to live in Monterrey after her husband passes away. She plans to live in her mother’s house with a brother who never married. Lupe’s family used to take vacations down to Monterrey every six months to a year, while Lupe’s mother was still living.

Lupe’s mother and father both had diabetes. Lupe herself was diagnosed in 1978, not long after her father’s death. Up until 1992, when her younger sister was diagnosed with diabetes, Lupe was the only one of her siblings diagnosed with diabetes. When she was first diagnosed, she had a bladder infection and went to see a doctor, who as Lupe put it, (translating from Spanish12) “got alarmed, ... and told me, you have a lot of diabetes, go to the hospital right away (luego luego), because you have a very high blood pressure, and it could give you a heart attack”. But she did not go, because “poverty does not permit one to do anything like that”. Instead, she took the medications he gave

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11 Lupe’s case is exceptional in two senses. First, she is one of four people who have ties (in her case marital, and then through her children and grandchildren) to non-mexicanos and/or non-tejanos. Second, she is the only person who mentioned that they had used a family member’s prescription for their own medication. However, a Spanish-speaking Anglo doctor I met during the research mentioned that at the San Antonio barrio clinic where she used to work, she knew that some of her patients were sharing medications with relatives (and she admitted that she collaborated with them in their efforts). Research shows that sharing all kinds of things is a common strategy to copy with poverty (e.g., Stack 1974, Lomnitz 1977). Lupe explicitly cited poverty as the reason she resorted to this strategy.

12 Lupe’s interview, as well as the interviews with the other people born in Mexico, were all conducted in Spanish. Throughout this section, I will be providing translations of longer quotes, occasional reminders that I am translating, and shorter phrases in Spanish, followed by English versions. Most of the interviews with the people born in Texas were conducted in English, however three were in Spanish, two in Spanish and English, and several others were mostly in English with some Spanish.
her and “did everything he said”. In three days, the bladder infection was alleviated, but from then on, “yo quedé con la diabetes; I stayed (or continued) with the diabetes”. Lupe said there were times that she would get up to 500, feel bad, dizzy, and sleep, but unable to sleep. But that was when she did not have medicine. She explained that “one could say that I did not have medicine, because I brought it from Mexico”.

Later in the interview, she explained, “my mother knew the condition of poverty that we were in, and she told me that I’ll send you medicine from here”. As Lupe explained:

Since my mother was a diabetic and she belonged to the Seguro Social. Over there Social Security is quite different than it is here, over there everything is, everything is free, as long as you are a member of the Social Security, and they gave her extra medicine, at the Social Security diabetes clinic, and she would send it to me.

Lupe’s mother’s access to the Social Security medical system (IMSS) must have been through her husband’s formal sector employment at a steel factory.

This transnational flow of medications went on for years, but there were difficulties. There were occasions when Lupe went without medications, such as when she had not gone to visit recently, and when her brothers did not have the time to make a trip up to the border, where they would cross over, and mail it to her. In addition, during the last ten years, the U.S. government passed legislation tightening up on the flow of prescription medications across the border. Any person carrying diabetes medication had to be diabetic themselves, and since none of her brothers were diabetic, they were afraid the medications might be confiscated and thrown away.

Finally in 1990, her mother passed away. At first, her brother promised that he would try to continue to supply Lupe with medications, but that got increasingly difficult, and Lupe went without medications for months at a time, until she finally decided to go to the county clinic.

13 500 refers to her blood sugar level. Biomedical practitioners regard 80-120 or 70-110 as normal, and recommend that diabetics try to maintain their blood sugar in this range. At the county clinic, they strive to at least get the blood sugars under 200, if not within the “normal” range.

in San Antonio. Within a short time, they put her on insulin, because they believed that the pills could not control her blood sugar levels. Lupe admits that her diabetes was “unattended” for years. Now she is getting some eye complications. During the interview, Lupe also stated that “poverty” made it difficult to buy fruits and vegetables, especially when the children were still at home. Furthermore, sometimes she does not go to her doctor appointments, because she does not have the 80¢ for the round-trip bus fare to the clinic.

Lupe’s poverty due to low-wage informal sector employment in the United States, made it difficult for her to access medical resources in the United States. So Lupe’s mother offered her access to medical resources in Mexico — specifically the Social Security system, through Lupe’s father’s formal sector employment. Lupe, operating under economic circumstances that limited her access to needed medical resources, did her best to maximize her access through her transnational social network. However, this meant that she went without medications for periods of time. Apparently she also did not consult physicians, who might have changed or adjusted her medications, or put her on insulin sooner. According to the biomedical model of the progression of diabetes, this means that during those times, she probably had high blood sugars, and high blood sugar levels affect blood circulation, the kidneys, and the nervous system, which can cause irreversible damage to the eyes, internal organs, and other areas of the body.

Besides obtaining oral medications through her mother, Lupe also obtained information about diabetes from her mother and from her niece’s husband who was a doctor. In particular, Lupe asked him to confirm something she had read in a medical journal in the United States. She said that he reluctantly confirmed that (prolonged) use of insulin can cause heart attacks. Lupe, like many of the interviewees, tended to cross-check medical information from all the sources to which she had access. Although Lupe only had a sixth grade education in Spanish and preferred to speak Spanish, she could make herself understood in English and she could read English. She learned about Western biomedicine by reading medical journals and books in English. For example, she had read the Harvard Medical Newsletter, to which her husband subscribed for some time, Prevention (a health magazine), and Profiles in Diabetes, a small book about famous
people with diabetes\textsuperscript{14}. Lupe also obtained and cross-checked information about herbal remedies on both sides of the U.S.-Mexico border.

Víctor Guerrero, age 43, also consults with Western biomedical practitioners on both sides of the border. He was born and raised in Nueva Rosita, Coahuila. His mother owned a restaurant and his father is a lawyer, and most of his siblings are professionals. When Víctor finished high school (preparatoria), he took off to San Antonio "por cabrón, por aventurero; like an idiot, for the adventure"\textsuperscript{15}, as he now puts it. He first worked with cement, and eventually started to work installing central air conditioning systems. Víctor met his wife (born in Sabinas-Hidalgo) in San Antonio, and by 1994 at the time of the interview, they had three daughters, ages 21 to 17, and two granddaughters.

Víctor was diagnosed with both diabetes and high blood pressure, after he had a heart attack in 1990. He lost his job as a result of the heart attack. Six months later, after he had recuperated, he figured out that he had to lie about his medical conditions in order to get a job. The

\textsuperscript{14} Profiles in Diabetes is a small paperback book, of the type one might expect to see near the checkout stand in the grocery store. Lupe showed it to me. It was primarily a list and/or photos of famous people who have diabetes (actors, musicians, and politicians, such as Mary Tyler Moore, Jackie Gleason, Dizzie Gillespie, Elvis Presley, Michael Gorbachev, and Tip O’Neill). The purpose of this book seemed to be to reassure a diabetic that they are not alone, and that many famous people have diabetes and are still living successful lives. Lupe told me that she thought it was interesting to find out that so many famous people had diabetes.

\textsuperscript{15} I translated the Spanish loosely. Cabrón (literally a large or old goat) is a stronger word than idiot, but I think "idiót" more or less gives the sense of what he meant in this particular narrative. Cabrón implies cuckingold, but cuckingold was not a factor in this narrative. Cabrón is also commonly used as a general insult for men. Víctor sets up a parallel structure in Spanish, "because (I was) a cabrón, because (I was an) adventurer". His father had urged him to stay in Mexico and get a university education. He did not, he took off for adventure, and now all of his siblings are professionals in Mexico, and he installs air conditioning systems in the U.S. and is struggling to make ends meet. Late in the interview, after several beers, he shed some tears about what he now considers to be a bad choice he made in his life. Víctor also has had problems with his middle daughter, whose husband is now in jail, and she now has several boyfriends. He thinks that this may be the reason that they had a drive-by shooting at the house a couple of months before I did the interview. Víctor had already repaired the damage, but he showed me where the bullets went. One went through two walls and into the refrigerator door in the kitchen, not to mention the ones that ricocheted off the window frame of the front bedroom inches away from the headboard of the bed where he was sleeping.

doctors at the county clinic in San Antonio originally recommended that he try to control his diabetes with diet only. He was given an appointment with a dietician, who gave him a lot of information, including that he should not eat flour tortillas and should eat with a fork\textsuperscript{16}. The day I recruited him for the interview (in 1994), his doctor recommended that he start taking an oral medication. Víctor goes to the county clinic in San Antonio about every three months for appointments, which is what is typically recommended for diabetes patients there.

Víctor said that he goes to Mexico about every six months, and when he goes, he always gets himself checked by a doctor there. That doctor happens to be his cousin. His cousin’s advice is “que no más me controle la diabetes, que siga la dieta; that I keep the diabetes controlled, that I follow the diet”.

Lupe and Víctor had the most direct contacts with the system of Western biomedical as practiced in Mexico. Martha Gámez (age 59) lived in Piedras Negras for years before migrating to San Antonio in 1984, and had interactions with medical practitioners there. She was diagnosed first with a heart condition and high blood pressure, and later with "un poco de diabetes". Because she also perceived it as only a little diabetes, she gradually fell off the recommended diet. The diabetes was re-diagnosed after she moved to San Antonio. She did not report any current interactions with doctors in Piedras Negras, although two adult children and their families all live there.

Both locally and transnationally, people do not only learn about biomedical information regarding diabetes through direct contacts with practitioners. This information also circulates among family members and friends who (explicitly or tacitly) share their experiences with the illness and its treatment. For people whose personal networks are transnational, information can flow both ways. María Martínez and Daniel Celestín not only learned information about diabetes or were given advice by family members residing in Mexico, but they also gave their family members advice, particularly about the use of insulin.

\textsuperscript{16} The doctor recommended that he eat with a fork, rather than use several tortillas to scoop up and eat food (i.e., the doctor was recommending that he eat less tortillas in general). At the county clinic, they recommend that people with diabetes switch from flour to corn tortillas, because flour tortillas are prepared with lard and corn tortillas are not. In San Antonio, flour tortillas are very popular.
Maria Martínez’s (age 60) was born in Allende, Coahuila, and migrated with her husband to Rafford, Illinois, for a number of years. Her husband worked in a factory there, but they always took annual family vacations to Mexico. Then, because her husband has always wanted to return to live in Mexico, around 1981 they moved to Monterrey, but only stayed there about four months. For the sake of their children’s education (who by that time were in high school and had had most of their education in English), the family moved to Eagle Pass for a year while her husband worked in Rafford, and then the whole family moved to San Antonio.

Maria was first diagnosed with diabetes in 1979, when she was living in Rafford. She followed a strict diet for a “long time”, but eventually got tired of it. She took pills for over ten years, and in San Antonio, in 1992, when she started experiencing eye problems, she was put on insulin. During the interview, María never mentioned consulting with doctors or purchasing medications in Mexico, although she probably did while she was living in Monterrey. Like Lupe and Víctor, she has family members who are doctors and pharmacists (químicas). She said she listens to their conversations. In general, María is a private person, who is not inclined to discuss her diabetes with friends and relatives. She keeps her husband informed, but doesn’t really talk to him about it, and she hasn’t talked much to her children about it. She also stated that when she was living in Rafford, she did not see her parents and brothers and sisters that often (no muy seguido), so she did not know that much about what had happened with her father’s and her sibling’s diabetes.

Maria described to me what she perceives to be a crucial difference between the way Western biomedicine is practiced in Mexico as compared to her experience in San Antonio (which I have translated from Spanish):

*MM*—In Mexico, I don’t know, but I believe that they have a different system of doctors.

*DP*—And in what sense do you believe that it is different?

*MM*—That they only give pills and never put them on insulin, unless they are already gravely ill.

She added that at first she did not want to be put on insulin either (because of the inconvenience), but that she would recommend to any of her siblings that they should go on insulin before they start getting complications.

I believe that María has identified not simply a “transnational” difference, but a broader shift in biomedical treatment protocols for adult onset diabetes, which is being implemented at varying rates by practitioners in local clinics in both the United States and Mexico. Based on continuing medical research, practitioners have begun to prescribe insulin to Type II diabetics who do not achieve adequate control through diet, exercise, and/or pills at earlier phases in the course of their illness, whereas in the past they waited to prescribe insulin until the person’s pancreas was almost completely worn out13. However, practitioners do not always explain to patients that there has been a change in treatment protocols. Meanwhile, many patients have relatives (or friends) who were treated (or are still being treated) under...
the "older" protocol —either in Mexico or the United States. Based on knowledge of their relatives' experiences (which one could say has become part of their "common sense"), they interpret the prescription of insulin as a sign that the illness has gotten much worse, and sometimes resist practitioner recommendations to take insulin. As we shall see shortly, this knowledge had a profound effect on Juanita Sánchez, who took care of her father right before he died. But first, we have the story of Daniel, who was prescribed insulin in San Antonio, and decided to openly share his experiences with family members on both sides of the border.

Likewise, diabetes treatment protocols appear to be changing in Mexico. In his ethnography of fifty residents of a low income barrio in Guadalajara, all diagnosed with adult onset diabetes, Mercado (1996:336-337) states that an ever-increasing number of doctors in Guadalajara are prescribing insulin in order to control the patients' diabetes. However, he notes that many of the people in the barrio who had been prescribed insulin, rejected it for various reasons, including negative effects on their health, such as causing blindness and dryness. (Except for this brief reference to insulin, Mercado's discussion of medications focuses on uses of pills and herbal remedies.) Mercado wonders whether this phenomenon of rejecting insulin occurs only in the region, or among the popular sectors in particular, or whether it is more widespread, and he cites this as an issue meriting further research.

Generally speaking, doctors in San Antonio also perceive patient reluctance to take insulin as a problem. In sum, it seems that differences exist between biomedical practitioners in terms of their approaches to adult onset diabetes treatments, with earlier stage insulin-based treatments being recommended, or at least implemented, more commonly in the United States than in Mexico. I suspect that such differences are not only due to access to recent research, but also to the availability of insulin and the costs for patients of the insulin, syringes, and refrigeration to keep the insulin cool, as well as lancets, strips, and other equipment to do blood sugar monitoring. In addition, Mercado's work and our study suggests that there are differences between practitioner and patient knowledge regarding insulin. This seems to apply to people living in South Texas and in Mexico, as well as to those who maintain contacts in both places.

Keeping in mind the fragmented ways that different people put together their knowledge about diabetes, it is worth noting here that Lupé Tamayo had an entirely different reason for initially resisting her doctor's prescription of insulin—i.e., reports in biomedical journals, which she double-checked with a doctor in Mexico, that prolonged use of insulin increases one's risk of heart attack (or perhaps more precisely, in studies has been correlated with increased heart attack rates). When I asked Dr. Pugh about this, she also confirmed this information.

Lupé's doctor's approach to her resistance was interesting. He asked her to humor him, and try insulin for one month as an experiment, and then after that month, she could decide whether it was a good idea to continue. In other words, he empowered her to make the decision. After that month, she did feel better and she decided that it was OK to continue. This example illustrates the negotiations involved in the education of consent.

Daniel Celedón, age 44, was originally born in Matehuala, in the state of San Luis Potosí. He started working at the age of 7. From the ages of about 15 to 20, he picked cotton and cut cane in Coahuila and Tamaulipas. Eventually he migrated (illegally) to the United States in the early 1970s, where he did ranch work and meat cutting for a San Antonio restaurant chain. He married his first wife (a mexicana born in San Antonio), and returned to Mexico for a year in order to apply for legal residency. For that year, he worked in construction in Monterrey, and his mother and other family members started moving to Monterrey.

When he returned to San Antonio, Daniel did six months of maintenance work, and then worked for a slaughter house from about 1977 until 1986. During those years, he separated from his first wife, though never officially got divorced. They never had children, but Daniel had three children by his second relationship. He was also drinking heavily in the cantinas on weekends. Then he got shot in the stomach at a cantina, hurt his arm in an accident at work, and was diagnosed with diabetes. Eventually he lost his job, because he could not do the heavy lifting (due to the combination of his injuries and ailments). He initiated a four and a half year legal struggle to get Social Security benefits. His second partner left him when he lost his job, and soon afterwards, he started living with a third woman.

In 1986, when Daniel was diagnosed with diabetes, he took pills for a year, but his sugar didn't go down, so he was put on insulin. He did not completely stop drinking until a year or two after he was put on insulin, when a doctor told him he was going to die if he kept this up, and Daniel decided "yo tengo ganas de vivir todavía; I still feel like living". Now that Daniel has stopped drinking and started taking better care of his diabetes, he says that he is very open about his diabetes with his families in the United States and Mexico. Sometimes he even
gives himself the insulin shots in front of them, so that they will see it’s no big deal.

Thus, both Daniel and María provided their families in Mexico with information about using insulin to control Type II diabetes. In terms of receiving information in or from Mexico, both Daniel and María stated that they did not see their families in Mexico that often (perhaps once a year) and therefore did not know much about their respective fathers’ experiences with diabetes.

However, during the interviews, they both discussed what happened to their fathers. María’s father died while she was living in Illinois. She knew that his leg had been amputated and that he “did not follow a diet”. Daniel stated that his father could not afford to go to the doctor, and when he did go, “his illness was very advanced”. When his father was no longer able to work, Daniel sent money when he could to cover his father’s medicines and doctor visits, but he admitted it was erratic, because “I had to eat too”. Daniel said that his father advised him:

que yo me cuidara, que no tomara tanto y que como yo estaba acá donde ganaba dinero pos (pues) comiera bien, comiera verduras y todo eso, porque eso tambien ayuda. Y si me sentia mal que fuera a ver un doctor, porque si yo tenia eso, pos que si podia vivir mas si tenia eso, pero que estar yendo a ver al doctor, que lo estén chequando.

that I take care, that I not drink so much, that since I was over here (in the United States) where one could earn money, well I should eat well, eat vegetables and all that, because that also helps. And that if I was feeling bad, I should go see a doctor, because even if I had that, well, that I could live longer if I had that, but to be going to see the doctor, that they should be checking it.

Thus, María and Daniel were generally aware of their father’s experiences, despite their own disclaimers, which I believe refer to what they perceive as a lack of knowledge about their fathers’ day-to-day care. Daniel was at least somewhat involved in his father’s care towards the end of his life. Both María and Daniel were giving and receiving information (and material resources) across the U.S.-Mexico border. Except for relatives who are medical professionals, the flow of information appears to differ in terms of generations. María and Daniel tended to receive information from parents and provide it to their siblings.

Juanita Sánchez, age 55, migrated from Michoacán to Nuevo Laredo, when she married her husband. Later the two of them migrated to San Antonio. They worked illegally for many years, and then legally (under the amnesty program) in the United States’ “informal sector”, with him doing mechanical work and her doing housekeeping. Juanita’s diabetes has come and gone since 1974. Like Daniel and María, she did not have direct interactions with medical personnel in Mexico regarding her own diabetes. However, Juanita went back to Michoacán to take care of her father during the last stages of his diabetes, and had several interactions with his doctor. She told me about the dietary recommendations that his doctor made for him, “*pura lechuga*, pure lettuce” (meaning eat lots of vegetables), and “boil everything” (as opposed to frying). She also said the doctor told her father that eating more was OK to have one beer a day, but she thought that was because her father was near the end. Along the lines of María’s observation, Juanita’s father was not prescribed insulin until close to the end of his life. In fact, Juanita would give him the shots. After he started taking insulin, and before he died, he went blind. He believed the insulin caused him to go blind, and because Juanita was giving him the shots, at one point, she accused her of helping him to go blind. He died in her arms.

At the time of the interview, Juanita had just been prescribed insulin and was trying to do everything possible, such as following a diet and trying herbal remedies, to avoid taking insulin. During the interview, she vacillated between saying that she knows she should take the insulin, because her doctor warned her that her pancreas was not producing enough insulin, and expressing her fears about taking insulin related to her days of caring for her father. Juanita’s lived experiences with her father’s illness, along with her recent interactions with the doctor and other experiences, all form part of her knowledge about diabetes. As Gramsci’s (1971) descriptions of “common sense” sug-

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21 María, until recently, and the whole time they were living in Rafford, Illinois, would go once a year to see family. However, she said that for personal reasons, she has not been back lately. Daniel mentioned going for family emergencies. He viewed it as a problem that sometimes “I can’t go see my mother, my people (mi gente)”. During the interview, I never asked Daniel how often he has gone to see his family.

22 Juanita used the phrase “se retiró” to refer to the times that her diabetes “retreated”.

gest, Juanita has been acquiring her knowledge over the years in fragments, some of which are contradictory. When I interviewed her, she was trying to work through some of those contradictions.

Lupe, Victor, Daniel, Maria, and Juanita all had at least one parent diagnosed with diabetes. (Both of Martha's parents died of heart disease.) They all had migrated to the United States as adults, while their parents remained in Mexico. Of the five whose parents had diabetes, Juanita was the most directly involved in the daily care of that parent. She returned to Michoacán to take care of her father during his final days. In contrast, the others knew the general course diabetes had taken with family members, but not all the details of daily care. Francisco Cortés did not talk about his parents, but he did talk about a brother in Monterrey with diabetes, who had died recently. Like Lupe, Victor, Daniel, and Maria, he knew the general course of his brother's illness, but not the details of daily care. Nevertheless, his brother's death had a significant impact on Francisco's approach to his own diabetes.

Francisco Cortés, age 63, was born in Saltillo. Later he worked in Monterrey, first as an errand boy for a bank, then at an American fiber company for 2 years, and finally at a beer bottling company. In the early 1960s, he was urged to come and work in a bottling company in San Antonio, but after he got there, the job fell through, so he spent one year working up in Wisconsin packing lima beans and one year in Oklahoma doing agricultural labor. His wife and children lived in Laredo during those difficult years. Eventually Francisco got a job in San Antonio working in a produce warehouse, and brought his growing family to live there. He quickly rose to the level of supervisor, and worked there for over 25 years.

Francisco got most of his information about diabetes from a private physician in San Antonio, who first diagnosed him in 1991, sat him down, and explained that he should stop smoking, stop drinking (both of which he did pretty heavily), and go on a diet, which the doctor explained in some detail. Francisco kept up the diet for about six months, quit drinking for about three months, and started a gradual campaign to cut back on his smoking. When he started feeling better, he gradually went back to his old eating and drinking habits, but continued his efforts to reduce his smoking. So by 1993, now retired, he went to the county's Walk-In clinic, showing various symptoms, and was again diagnosed as having diabetes. That day his wife says he walked in the door with a grocery bag full of diet foods. Francisco also quit drinking, and said that this time, he planned to quit completely, because he felt so much better, could think more clearly, and in retrospect, saw all his years of drinking as a waste of money.

His wife stated that he was motivated by "fear", because in between the first and second diagnoses, his brother in Monterrey had died from complications related to diabetes. Francisco prefers to view his motivation as "precaución". Francisco did not mention consulting with any doctors in Monterrey (where his family lives) or Nuevo Laredo (where his wife's family lives). Thus, he does not appear to have any direct contacts with the biomedical system in Mexico, but in general he knew of his brother's experiences with diabetes.

In sum, one person, Lupe, acquired oral medications in Mexico through her mother who also had diabetes. The seven Mexican had contact with the biomedical system in Mexico that ranged from direct contact through consultation with doctors about their own diabetes, to interactions with doctors treating family members, to more indirect contact through observations of and/or conversations about the experiences of family members. With the exception of Juanita, who was directly involved in the daily care of her father, most of the people

\[23\] By diet foods Fernando meant low-calorie low-fat frozen dinners that you could heat up in the microwave. (In this way, the person does not disrupt what the rest of the household eats, but the other interviews suggest that this strategy usually proves to be expensive and difficult to sustain in the long run.) Francisco was one of the interviewees who perceived "going on a diet" as having to give up most of his favorite foods, such as pork chops. During the interview, Francisco did not mention diet strategies, such as reducing the fat content of Mexican-style dishes that are prepared in the home.

\[24\] This was Francisco's own assessment of his situation. Nevertheless, however much he may have been drinking and however much it may have cost him, their living room wall was covered with the high school graduation photos of all five of his children plus an Anglo boy they adopted.

Francisco told me that when he returned to the Walk-In clinic for a follow-up visit, after he had given up the drinking and started eating the "diet" foods, the doctor was so amazed (that someone he assumed was a "newly diagnosed" patient had achieved such good blood sugar control) that he called in the other doctors to see his "case". At this county clinic, about 50% of the daily case load has diabetes. The doctors in the Walk-In clinic diagnose at least one "new" case of diabetes a day. They frequently see people with blood sugars in the 300's and 400's. The Walk-In clinic doctors refer "newly diagnosed" patients to a primary care physician in the Internal Medicine clinic and to diabetes education classes, and eventually patients are also scheduled for appointments in Podiatry and Ophthalmology.
indicated that they did not talk much about the day-to-day details of caring for a chronic illness when they went to visit their relatives once or twice a year.

However, the general nature of their knowledge about the illness experiences of their parents and siblings in Mexico is not simply due to the fact that these are transnational or cross-border contacts. Many of the **tejanos** did not talk much about diabetes with their family members or notice what their relatives were doing about it, until they themselves were diagnosed. After the **tejanos** were diagnosed, they varied as to how much they talked about diabetes with their relatives. Some also had only general knowledge about their relatives' experiences with diabetes, but did not know much about the specifics of their daily care. Some, like María, tended to be private about their illness; while others, like Daniel, shared details of diabetes care with family members. Nonetheless, having relatives (with diabetes) living nearby seems to have facilitated—if not the explicit, then the more tacit—everyday circulation of knowledge about diabetes among extended family members. I would suggest that poverty limited the ability of the **mexicanos** to visit with their extended families in Mexico to about once or twice a year, which by extension, limited their opportunities to gather (explicitly or tacitly) information about their relatives' experiences with diabetes.

**Border Crossings for Biomedical Care by Tejanos**

Of the thirty-five people interviewed, twenty-eight were born in Texas, generally either in San Antonio, smaller towns near San Antonio, or somewhere in South Texas, i.e., in part of what Américo Paredes (1958) refers to as “Greater Mexico.” About half of the twenty-eight **tejanos** had parents, grandparents, and/or spouses born in Mexico. Two had both parents and all their grandparents born in Mexico (though in Carmen Luján’s case, her mother died when she was young, and the stepmother who raised her was born in San Antonio). One person, Priscilla González, had a mother born in Panamá. Priscilla’s father, a Mexican American, met his wife in Panamá while serving in the U.S. military, but not long after that, he got out of the military and they raised their family in San Antonio. Priscilla’s father was born in Texas, as was his mother, while his father was born in Monclova, Mexico (near the border). Six people had one parent and that set of grandparents born in Mexico. Four had one or more grandparents born in Mexico. All the other parents and grandparents of these ten people were born in Texas. Fifteen people stated (or implied) that all their parents and grandparents were born in Texas.

Four of the twenty-eight had spouses born in Mexico, and of all the **tejanos**, they were the most likely to mention having gone to Mexico recently to visit family. In other words, some **tejanos** used to visit grandparents and aunts and uncles in Mexico as children, but had not gone much in recent years, since they themselves were now grandparents.

Despite family links to Mexico, the **tejanos** living in San Antonio had little to no direct contact with the formal biomedical system in Mexico. In fact, the only person who mentioned any contact was Javier Peña, who used to live on the border in Brownsville and Del Río. He talked about considering the option of buying his diabetes pills in Mexico, because they were cheaper. However, ultimately he decided to buy his medications on the U.S. side of border. As he put it (in English): “Sometimes you feel that the pills they give you over there in Mexico, they're not, don't do the work, so heck [I'd] rather pay a little higher and [get] the right medication.”

Thus, the **tejanos** had almost no direct contacts with the formal biomedical system in Mexico. Furthermore, there was very little mention of indirect contacts through conversations with family or friends. As the more detailed stories of the **mexicanos** suggest, their contacts with the biomedical system in Mexico were generally made through their parents and siblings still living in Mexico. For the most part, the parents and siblings of the **tejanos** lived either in San Antonio or in South Texas.

**Crossing medical borders: curanderos and herbal remedies**

Both in Mexico and in Texas, there are “alternative” (as in alternative to biomedical or allopathic) health care options. These could include consulting with a **curandero**, and purchasing or acquiring,  

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25 In a few of the interviews, they were not directly asked about their grandparents, but during the interviews, they never mentioned having any family in Mexico.

26 As already noted with the **mexicanos**, the relative poverty of all of the interviewees tends to limit the possibilities for travel to Mexico. Thus, the **tejanos** tend to prioritize visits with parents, adult children and grandchildren (all living in the United States) over visits with more distant family (in Mexico). In addition, many of their older relatives in Mexico are no longer living.

27 Javier’s interview was taped, and the bracketed words were difficult for the transcriber to hear. I also use brackets around words that I fill in from interviews in which only notes were taken.
preparing and drinking herbal teas and other home remedies. These “alternative treatments” represent another kind of “border crossing”, in which individuals cross the “border” between Western biomedical and Native American and/or Mexican traditional healing practices. Several of the interviewees associated herbal remedies with “Mexico”, but given that Texas was for many years part of Mexico, it is possible to obtain that cultural knowledge without ever crossing the political border as it exists today. Western biomedicine and traditional healing practices exist on both sides of the political border.

Only one person, Joe Fuentes (age 59; born in Laredo, Texas; and diagnosed with diabetes for less than a year at the time of the interview) mentioned having gone to a curandero in San Antonio for symptoms associated with diabetes. At the time, he thought that his symptoms (e.g., tiredness) were due to depression. He had lost his wife to cirrhosis of the liver, and was worn out from raising two teenagers on his own. When the consultation did not result in any improvement, he went to the county clinic, where he was diagnosed with diabetes. Now that he knows he has diabetes, he has no plans to consult again with a curandero. He now attributes his initial efforts to attend to his problems through a curandero as “ignorance”. However, he was very interested in herbal remedies, and shared with me a 2-page list of herbs and illnesses given to him by professor at a local university.

Four other people (one mexicano, and three tejanos) recalled having gone or being sent to a curandero as children. But, no one said they were currently seeing one, or had any plans to see one, at least not for their diabetes. In fact, Blanca Macías (born in a small town in south Texas) explicitly stated that she thought curanderos were good for certain ailments, such as empacho and susto, and that she used to take her children to a curandero for these ailments when they were younger, but she would not go to see one for her diabetes.

None of the interviewees mentioned consulting with chiropractic or homeopathic practitioners for their diabetes.

At least two of the interviewees talked about herbal remedies being “Indian”.

Empacho and susto are generally described in social science literature as “folk” or “traditional” ailments, found not only among Mexican Americans, but also in Mexico and other areas of Latin America. Rubel (1966: 256, 259, 161-167) defines empacho as “an illness presumably brought on by the sticking of a piece of food to the intestinal tract”, and susto as “an illness associated with the loss of one’s soul” caused by a frightening incident or one in which a person performs inadequately and is taunted by others.

Three others (one mexicano and two tejanos) knew people who had consulted curanderos, but were not inclined to consult one themselves. Victor Guerrero (mexicano) and Gilbert Suárez (tejano) mentioned that their spouses and in-laws (all originally from Mexico) had told them that they should consult a curandero. Victor was very critical of these practices, stating emphatically that he prefers doctors. Gilbert said that his wife was cured of paralysis after she consulted with a curandero, but that he personally does not have “faith” in it. Nellie Holguín (born in Salado, Texas) spoke of a relative who went blind, and after six months was cured by curanderos and (biomedical) doctors, but she was not planning to consult one herself.

In contrast to the relatively few reports of using curanderos, many of the interviewees talked about hierbas or herbal remedies. Most people had heard about hierbas from friends and neighbors. They obtained the ingredients from plants in their own yards, or the yards of friends and relatives, or from grocery stores or hierberias locally or from across the border. Some people knew about hierbas, but hadn’t tried them. Others had tried hierbas a few times, but for several different reasons, decided not to use them. Others were using herbal remedies on a fairly regular basis. In general, people who used herbal remedies tended to view them as a supplement to rather than a replacement for treatments recommended by Western biomedical practitioners.

In terms of transnational articulations, two mexicanas cited a Mexican source for both the information about hierbas and the purchase or acquisition of the particular hierba. María Martínez bought a packet of herbs while in Mexico, thought they tasted “feas” (awful), and after two months, tossed the package out in the trash. She says she does not have “faith” in hierbas. Martha Gámez tried té de malabar. Martha’s daughter lives in Piedras Negras and her mother-in-law (also diabetic) drank this tea and recommended it, so Martha’s daughter brought Martha some. She tried it, but stopped drinking it when she had to be hospitalized. Her daughter is planning to bring her another package, and Martha is planning to continue drinking the tea.

Two tejanos had heard about herbal remedies locally, but saw Mexico as the place to purchase them. Rebeca Rocha heard about nopal pills from a friend and was planning to ask her brother-in-law, who was going to Mexico, to buy her some. Javier Peña was told by fellow walkers at the mall, some of whom are “from Mexico”, that he should go to a certain shop in (Nuevo) Laredo to buy herbal remedies, but he’s never tried to go.
Three *mexicanos* and four *tejanos* combined various sources of information from Mexico and/or Texas and then acquired the remedies either locally or from Mexico. For example, Bridgette Bailey got advice from a friend from their migrant labor days in Indiana. Her friend still lives in Indiana, but goes to Mexico every year. Bridgette’s friend recommended a *hierbabuena-estafiate* mixture to Bridgette and brought her some from Mexico. Bridgette’s friend also recommended *nopal*s. This recommendation was reinforced by a lady “at the hospital” (i.e., the county clinic), who recommended that Bridgette buy *nopal* pills. Bridgette bought the pills, but said that she had not started to use them yet. Bridgette is familiar with several local *hierberías* and reads the pamphlets that they provide. However, all this activity was in addition to the five diabetes education classes, which she was faithfully attending at the clinic, after having been recently diagnosed at the time I interviewed her.

One *mexicano* and twelve *tejanos* acquired their information about *hierbas* locally (in San Antonio) from friends, relatives, acquaintances, or the ubiquitous “they say” or “I’ve been told”. Then they either picked the ingredients for the various remedies off their own trees and plants or those of neighbors, friends, or relatives (a highly affordable health care option), or they purchased them at local *hierberías*, or as Gigi Herrera put it (in English and Spanish), “you can buy them anywhere, *hasta los HEB*” (a large local grocery chain, originally founded in San Antonio). Carmen Luján told me that, if she wanted to, she could purchase *hierbas* from her “sisters” at the Jehovah Witness Church.

Four *tejanos* stated that they did not use herbal remedies. One *mexicano* and six *tejanos* did not discuss herbal remedies. Miguel and

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31 Bridgette is Mexican American. Her real last name as well as the pseudonym are Anglo, because her husband’s father was an Irish American Texas ranger who married a Mexican American woman. Bridgette’s husband seems to identify more with his *mexicano* heritage. As only one example (because I do not want to equate identity with language use), I conducted the interview with Bridgette and her husband primarily in Spanish. They generally speak to each other in Spanish and watch the Spanish-language television networks. As another example, Bridgette cooks *menudo, marrano, pork chops, tortillas de maíz, gorditas, chicarroncitos*, etc., for the family.

32 During the interview, she showed me the bottle, which had a price tag of $12.

33 Information circulated in these ways can be regarded as part of “common sense” (as conceived by Gramsci).

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I did not think to ask them directly about it, nor did they mention it as something they were doing.

Thus, only two interviewees (both *mexicanos*) relied primarily on Mexican contacts for information about and the acquisition of herbal remedies, whereas nine (three *mexicanos* and six *tejanos*) used both local and Mexican sources, and thirteen (one *mexicano* and twelve *tejanos*) used only local sources. Clearly, knowledge about herbal remedies and the herbs themselves are available locally. It is not necessary to cross the U.S.-Mexico border to obtain them. Nevertheless, several interviewees who had social networks (of family and friends) that extended into Mexico did acquire information and/or remedies from Mexico. These tended to be the *mexicanos*, but also included six of the *tejanos*.

Although the *tejanos* reported little to no contact with the biomedical system or *curanderos* in Mexico with regards to their diabetes, at least six talked about obtaining herbal information and/or remedies in Mexico. These contacts were often made indirectly through family members or friends traveling back and forth to Mexico, and in at least one case (Javier Peña), the individual had not yet followed through on an acquaintance’s recommendation to purchase *hierbas* in Mexico. Overall, the *mexicanos* tended to obtain all or some of their herbal information and remedies in Mexico (though one relied on sources in Texas), while the *tejanos* either obtained them in Mexico and Texas or only in Texas. In general, the interviewees tended to access knowledge of herbal remedies through networks of family, friends and acquaintances, wherever these were located.
The most commonly mentioned herbal remedies included:

* Nopales (mentioned by 9 people)
This is prickly pear cactus, which when talked about in English was usually just called “cactus”, and is either eaten cooked or raw, and as noted above, is also available in pill form.

* Aloe (mentioned by 6 people)
This is called sávila in Spanish. The viscous part inside is either chewed, or more commonly made into or combined with some kind of drink.

* Chinese plum (mentioned by 5 people)
This is called níspero in Spanish. A tea is made from the leaves of the tree.

* “Herbs” or herbal packets (mentioned by 5 people)
These had unspecified ingredients, although one mentioned the presence of “little bark pieces”. These are available for purchase in Mexico, or locally from your sisters at the Jehovah Witness Church, the HEB, hierbas, or other sources.

* Teas (mentioned by 4 people)
The interviewees did not specify the contents of these teas.

* Bark or huisache tea (mentioned by 2 people)

* Avocado seed tea or “agua” (mentioned by 2 people)

* Garlic (mentioned by 2 people)
This was mentioned twice in reference to diabetes, but more commonly was named as a remedy for high blood pressure.

There were also other remedies cited by only one person. These include: a hierbabuena-estafiate mixture for a tea, té de malabar, té de tila, pineapple core ground into a juice, palo azul, agua de buzal, maguay, a spoonful of olive oil, and vitamins (potassium and calcium) purchased at the GNC health food (a U.S.-based chain). This is not to mention the people who say they also use aspirins or Anacin. To this, we can add the non-ingested remedies mentioned, which were Epsom salts and vinegar baths, and massages from the leader of a “Metaphysics” group, who lived in San Antonio, but was originally from Mexico.

Herbal remedies were rarely used as a substitute for biomedical medications; rather, they were almost always seen as a supplement. Attitudes ranged from believing that hierbas do lower my blood sugar; to believing they work, but not being able to tell whether the effects are due to the herbs since I’m taking both medications and herbs; to the view that I’ll drink an herbal tea, “as long as it doesn’t harm me”. A couple of people believed hierbas worked, but since they were taking medicines prescribed by biomedical doctors, they did not want to take the risk of mixing medications. Then there were those who decided not to use hierbas for other reasons. Ricardo Machado (tejano) stated that he would have to know two or three people who had tried it, before he would try any home remedy. Mario Echeverria stated that his mother had tried eating nopales, and it didn’t do her any good, so he had no plans to try it. Four people, after trying various teas once or twice, rejected them based on taste—they were “awful” (“feo”), “bitter”, or “weird”. Five people believed that herbs were good for other things, such as a flu, but not for diabetes. One of them, Robert Ríos, believed that doctors (meaning biomedical practitioners) have “the most up-to-date medications”.

**Conclusion**

Gloria Anzaldúa (1987: 63, 78) characterizes life in the “borderlands” as a “struggle of identities”, a “struggle of borders”, which she frames primarily in terms of the struggle between Anglo-American and Mexican cultural values (with the latter entailing yet another struggle between Spanish and indigenous values) in the lives of Chicanos living on the U.S. side of the political border. She suggests that “the new mestiza copes by developing a tolerance for contradictions, a tolerance for ambiguity” and advocates that “in attempting to work out a synthesis”, there is “the possibility of uniting all that is separate”, of creating a sum which is greater than its severed parts, i.e., a new mestiza consciousness (1987: 79-80). In terms of medical practices, it appears that the low income Mexican Americans that we interviewed in San Antonio are attempting to work out a synthesis of all of the medical options available to them in the cultural borderlands in which they live.

This paper has explored how they use options other than the biomedical clinic in San Antonio at which they all receive services. The interviewees critically assessed (in terms of efficacy and other criteria) the practices of curanderos and herbal remedies, many of which have indigenous origins. Though not explored in detail here, the
interviewees, at times and in certain ways, were also critical of biomedical treatment recommendations. Nevertheless, as Gramsci’s formulation of hegemony suggests, they tended to privilege biomedical practitioners and treatments, while viewing curanderos as possibly appropriate for ailments other than diabetes, and herbal remedies as “supplements” which might help.

On the other hand, to bring the question of medical and political border crossings and transnational articulations full circle, both Juanita Sánchez (mexicana) and Ricardo Machado (tejano) had a logic whereby they concluded that hierbas in general are good, because they are “natural”, closer to the earth. Juanita asked me (in Spanish), “Aren’t most medications made from herbs? ¿verdad? (right?) or what, who knows?” Ricardo told Miguel (an anthropology student) that he had read about anthropologists who travel to Mexico and South America and extract herbs, that are used to prepare synthetic drugs. In other words, Juanita and Ricardo define the value of biomedical drugs in terms of their connections to hierbas, which are more “natural”, and they view the borders between biomedical drugs and hierbas as ambiguous.

In this paper, I have tried to illustrate the ways in which transnational articulations occur in everyday practices related to diabetes care in the lives of the people we interviewed. In the cultural “borderlands” of South Texas, the low income Mexican Americans we interviewed crossed various medical, political, and cultural borders in order to obtain medical information and remedies.

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