

Out-of-Sync Cancer Care

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

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

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

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

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

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

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

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

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

She turns from the computer screen and looks at Pepe.

“You have filled out all the forms correctly—I can tell. The original prescriptions are here [she points at Pepe’s plastic bag], as well as a copy of your medical history. There is nothing missing. The problem is that the medications are still out

of stock in our partner pharmacies. We will give you a call as soon as the rest of your drugs become available.”

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

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

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

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

My focus in this chapter is on physicians’ practices and interpretation of their work and their relationship with health insurance companies. I discuss how they

interact with the local medical bureaucracy and how they use what they have at hand to guide their practice and, therefore, medicine. How do oncologists provide care when they get caught between the time needed by insurance companies to get a financial return on their investments and the time when their prescribed chemotherapy would be beneficial for patients?

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

LEY 100 AND UNIVERSAL HEALTH CARE

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

Arguing lack of fairness, corruption, and inefficiency, the Colombian government enacted Ley 100 in 1993 and transformed the model of health care delivery. Its main goal was to guarantee universal access to medical services—regardless of preexisting conditions, socioeconomic backgrounds, and diagnoses—through mandatory health insurance plans provided by EPSs.⁵ As explained in the introduction, these insurance companies are a mix of public and private investors that

are intermediaries between the government, health care providers, and patients. The creation of these companies helped consolidate the meaning of health as an individual responsibility to be purchased (Abadía-Barrero 2022).

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

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

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

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

Brazil took a somewhat different path during the 1980s. It unleashed a health care reform “that culminated in the recognition of health care as a right of citizenship and the creation of the public, universal Unified Health System (SUS)

enshrined in the constitution of 1988” (Vieira and Azevedo e Silva 2019, 2). But implementation has proven difficult. During the 1990s, neoliberal reforms were adopted. In sync with other reforms in the region, the Brazilian government sought to separate funding from the provision of services, assemble basic service packages, and give priority to the care of low-income citizens.

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

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

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

Thus, making patients waste time becomes a mechanism for maximizing profit and successfully meeting the health care system’s bureaucratic procedures (Abadía and Oviedo 2009; Mulligan 2016). This is what so many patients like Pepe experience when their high-cost chemotherapy regimens are less likely to be provided according to their oncologists’ timelines. Rather, access to high-cost chemotherapy infusions is systematically “spread” over time, from every few

weeks to every several months. Patients are then pushed into a whirlpool of stress and emotional exhaustion, which recent clinical research has associated with increased risk of developing certain cancers and more aggressive metastases (Yang et al. 2019).

WASTING TIME, MAXIMIZING PROFIT

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

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

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

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

In exchange for enrolling Colombians, the government pays EPSs the equivalent of a premium. This payment is known as *Unidad de Pago por Capitación* (UPC), or annual fee per enrollee, which in 2016 was approximately US\$220 for the subsidized regime.¹² With this amount, EPSs are expected to cover enrollees’ annual examinations, treatments, and hospitalization costs. This fee is also used to

cover EPSs' administrative and operational costs. In other words, these businesses are expected to maintain a positive balance between the premiums they get paid annually (UPC) and the treatments they must provide to guarantee citizens' right to life and health. Any surplus amount is to be reinvested in the EPSs themselves, growing their market share and generating profit.

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

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

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

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

see as the time they need to increase profit and spend wisely. This is an economy of growth that is out of sync with cancer growth.

BUREAUCRACY, CHEMOTHERAPY, AND CAPITAL ACCUMULATION

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

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

These questions—the temporal urgency of oncology and the toxic and potent nature of treatments trouble cancer patients in Colombia, as they do elsewhere. From the urgency of rapidly dividing cells to the hours spent at insurance offices and receiving chemotherapy infusions, “a cancer diagnosis hurls one into a therapeutic pipeline at great speed,” Julie Livingston (2012, 19) explains. In the US, Lochlann Jain refers to this temporal urgency by explaining how the possibility of this disease pushes people to use their savings to pay for costly screenings and medical interventions that promise to catch cancer “in time.” In the US, where health care is not universal,¹⁵ patients often have to pay out of pocket for costly

treatments. In this context, postponing medical spending to a later time to treat a growing tumor would be an irrational choice; patients will not be able to enjoy their savings once their tumor has metastasized and their physical health has deteriorated (Jain 2013). What is the point of waiting, therefore, if patients in the US could use their savings now—or at least apply for credit—to maximize their chances for living longer?

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

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

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

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

This means that the bureaucracy encountered by most low-income patients is not simply an instrument for insurance companies’ premeditated delay or control of the provision of services, but rather a constitutive practice of their financial

rationality, of medical knowledge on cancer care, and even of the hospitals' rules. Practices, after all, do not simply describe realities but also tend to bring these into being (Mol 2002; Law 2008).

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

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

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

RHYTHM AND THE IMAGINED TIME OF ONCOLOGY

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

Scott Stonington (2020b) has written about medical decision making in the US amid flows of urgency and partial information at an ICU. In the midst of uncertainty and urgency, he explains, there are several rhythms that inform clinicians' decision making. In the case of patients' physiological rhythms, Stonington draws our attention to some continuous forms of data like pulse oximeters that provide

“second-by-second readings of arterial oxygen concentrations” (349) and others that are periodic, like blood pressure cuffs firing automatically and reporting results every few minutes.

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

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

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

specific ethnographic example of how the rhythm of medical events unravels in a private clinic in Cali.

MELANOMA SYNCHRONICITY

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

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

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

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

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

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

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

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

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

Antonio asked, "But how much longer?"

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

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

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

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

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

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

THERAPEUTIC DISJUNCTURES

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

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

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

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

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

MOVEMENT WITHOUT MOTION

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

of and give answers to patients, palpate bodies, write prescriptions, give legal advice, and fill out forms.

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

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

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

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

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

Initially, Pepe consulted a general practitioner at the local clinic in Río Frio, a small town near Cali, about heaviness in his stomach and heartburn. As described in a copy of the clinical history he shared with me, in June 2011 generic omeprazole—used to treat reflux and peptic ulcer symptoms—was prescribed. Pepe recalled this time when his stomach cancer had not been yet diagnosed: “I was on omeprazole for at least three months, until the symptoms were unbearable,

so I got really upset with the general practitioner. I told him my symptoms had not improved.” His condition worsened. He lost his appetite. In September 2011, after fruitless attempts to control what appeared to be severe gastritis, Pepe was finally referred to a gastroenterologist at HUV in Cali.

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

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

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

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

At the insurance office, Pepe handed the endoscopy and biopsy orders to the representative. He waited in line and became irritated. He yelled; his cheeks

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

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

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

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

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

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

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