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UTILITARIAN AND COMMUNITY VALUES IN MAINSTREAM AND
ALTERNATIVE HEALTH CARE ON MARTHA'S VINEYARD

BY

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DISSERTATION

Submitted in partial fulfillment of the requirements for
the degree of Ph.D. in Anthropology
in the Graduate School of
Binghamton University
State University of New York
2018

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Accepted in partial fulfillment of the requirements for
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2018

May 6, 2018

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Abstract

Problems endemic to Martha's Vineyard's health care system and community efforts to resolve such problems led to the choice to conduct this community study on Martha's Vineyard, Massachusetts. Such problems included Martha's Vineyard's sole hospital and nursing home's declarations of bankruptcy in 1996, the fluctuation of the quality of Vineyard health care organization relations with the community overall, the rate of uninsured that was two times that of Massachusetts overall, the Island's isolation from mainland medical specialty services, and its recurring health care service scarcities. This ethnography focuses on utilitarian values to explain difficulties that Vineyarders experienced during their efforts to obtain health care and their efforts to improve Vineyarders' access to health care. Efforts to promote access included the development and utilization of health care policies and the formation of mainland and local organization business networks and of local community networks (Wellever 2004:228, 229-230) such as the Dukes County Health Council.

Participant observation, structured interview (n=262) and archival data were used. Participant observation took place at town, Martha's Vineyard Commission and other public meetings, and at events such as the annual Tisbury town picnic, the annual West Tisbury holiday party, the Chilmark Community Center 50th year anniversary celebration, and the annual Wampanoag powwow. Structured interviews were sought from

Vineyarders who had expressed an interest by their positive or negative statements about health care. The *Martha's Vineyard Times Supplement* (2006) list of property owner names and their property values enabled interviews with Vineyarders of a wide range of property assessment values whose interviews were solicited by way of cold-telephone requests. Still others who had been employed by or had volunteered for a health care organization were found through recommendations, health care organization and other Vineyard media that listed or discussed trustees, top administrators and clinicians, and chance encounters during participant observation.

This dissertation uses content analysis of actions performed by those individuals, organizations, and communities of interest here. Utilitarian values were used to explain Vineyarders' actions. The types of utilitarian values of interest were not mutually exclusive and could be thought of as "existing" along a continuum of egoistic (individualistic) utilitarian values and collectivistic utilitarian values. Further extremes along such a continuum could be thought of as exploitive egoistic and altruistic collectivistic values. Such a continuum tends to be fluid at any given moment and across time. Such fluidity could be exemplified by an individual's or organization's self-motivated actions that produced benefits for those they exploited. Put another way, exploitation between two parties could be mutual. Each could exploit the other and thereby, each could give up something and each could gain something by the transaction. Also, those who took part in promoting the community's well-being most often (if not always) derived personal satisfaction from their altruism.

Though Martha's Vineyard's communities were diverse, Vineyarders tended to be united by their sense of community. They made efforts to protect their communities from those they believed held opposing definitions that could threaten their communities. Such threats led Vineyarders to strengthen their community ties and to form new communities. Arguably, the malleable, versatile (Cohen 1985:18) and imprecise (Cohen 1985:21) symbol, "community," promoted Vineyarders' social solidarity. Their belief in "community" promoted harmonious social relations because it enabled individuals to reach surface agreements (Cohen 1985:18, 109).

Dedicated to my mother, Barbara M. Polleys Parker,
esteemed giver and protector of life

Acknowledgments

This work likely would not have been completed were it not for my committee members. Professor Tom Wilson, chairman of my dissertation committee deserves many thanks for admitting me to his anthropology boot camp and for the challenges he provided there. He was an excellent advisor. He and the other committee members set excellent examples, provided excellent suggestions, led me to helpful resources, and helped me to greatly improve my writing skills. Professor Mike Little shared his wisdom since my first day at Binghamton University until the completion of this dissertation (and certainly afterwards, given all that he imparted). His unwavering patience, gentle prodding, extra miles he traveled for students, and clarity imparting anthropological concepts during his classes and during our meetings are greatly appreciated. Without his advice, this dissertation might not have been completed. Professor Gary M. James deserves thanks for planting seeds that promoted my understanding of, among other things, rural health care and health care networks. Professor Gale A. Spencer deserves lauds for her heroic efforts and her helpful insights. It was a pleasure working with these professors and also with Dr. Louise Stein of SUNY Brockport who provided guidance early in my doctoral studies. Regretfully, I did not have the chance to express my gratitude toward Dr. Richard Antoun for the wisdom he shared.

Thank you Vineyarders. While the scenery on Martha's Vineyard is spectacular, it is Vineyarders who made the Island a wonderful place. Thanks to those who took part in interviews, conducting interviews was one of, if not *the* most enjoyable experience during my fieldwork. Each interview enriched this work. Study participants shared generously during lengthy interviews. Vineyarders who politely declined being interviewed are appreciated as were those who stated that they were not interested in being interviewed but would do so if it was difficult to find study participants. Fortunately, such offers were declined thanks to Vineyarders' overwhelming generosity. My appreciation extends to moderators, committee members, political office holders and citizens who made their voices heard and who enabled me to see how Vineyard governance was played out at town, Martha's Vineyard Commission and other public meetings. Christine Brown who chaired the Martha's Vineyard Commission was among my Vineyard role models. Vineyarders with whom I laughed and with whom I mourned led me to feel welcomed as a community member. It is with a deeply-felt appreciation to have shared Vineyard sentiments such as those expressed while the Martha's Vineyard ferry, *Islander* that touched the hearts of many Vineyarders, was being decommissioned.

Vineyarders Sarah Kuh, Mary Leddy, Cynthia Mitchell, and some early study participants provided valuable comments that helped me to improve my interview schedule. Roger Wey helped me to improve questions to political office holders. Anna and John Alley shared their friendship and provided feedback on a dissertation chapter. Tim Walsh enabled me to conduct interviews at Martha's Vineyard Hospital and Dr. Denise Fraser provided me the green light for interviewing physicians employed by the

hospital. Didie Wieler offered to collect written responses to a request to be interviewed from hospital physicians. Though no physicians responded to this one item questionnaire, many agreed to be interviewed and all provided valuable data. Many Vineyard health care professionals of all ranks were excellent providers of health care given the observations I made and the accounts study participants provided. They have touched the hearts of many Vineyarders in immeasurable ways. The quality of their health care was a significant factor that led several study participants to make the choice to stay on Martha's Vineyard for health care. The directors of Edgartown, Oak Bluffs, Tisbury, West Tisbury and Chilmark Libraries and library staff of these and Aquinnah Libraries, the staff at *Vineyard Gazette*, *Martha's Vineyard Times* and Martha's Vineyard Museum libraries and the staff at Martha's Vineyard Commission and in each Martha's Vineyard town offices are much appreciated for their help with archival research.

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Thank you Vineyard family members. My choice of a fieldwork site where some genetic relations lived was made with reluctance. Words cannot express my deep appreciation toward Barbara Mae Polleys Parker for her care and her unspoken wisdom that taught me to put things into perspective. This study led me to notice and appreciate her assimilation into Martha's Vineyard's culture. Her spirit continues to be felt though she made her grand departure on May 22, 2016. My mother's husband, Charlie Parker deserves thanks for his heroic task of caring for my mother at home. My sister and my map and compass, Sue Polleys, deserves appreciation for her astute observations about the Island's natural surroundings. My brother Jonathan and his wife Tina (Gilkes) Polleys provided significant help while in the field. Tina provided insightful comments about Martha's Vineyard health care organizations. Jonathan and his friends helped me to move from West Tisbury to Vineyard Haven. My Vineyard family members and friends who welcomed me to stop by any time for a drink of water helped sustain me during my relatively long bicycle rides.

My appreciation extends to Vineyarders who worked on behalf of the Island and its communities. While Vineyarders and other islanders shared similar problems, undoubtedly, Martha's Vineyard is a special place if for no other reason than that no two people, no two grains of sand, and no two molecules could exist during the same time within the same place. However, there is much more that makes Martha's Vineyard uniquely wonderful. That of the utmost importance is that Martha's Vineyard ethos in which each of you have played a part. Thank you all acknowledged here again and again.

Table of Contents

List of Tables	xv
List of Figures	xvii
List of Abbreviations	xviii
Introduction	1
Study Site: Martha’s Vineyard	1
Problems that Led to This Dissertation	7
Community and Values Provide Keys to Understanding	14
Utilitarian Values	16
Martha’s Vineyard Health Care Communities	18
What This Dissertation Argues	22
Relevance of Community to Martha’s Vineyard	25
Study Methods	25
Data Analysis	35
Order of Chapters	38
Chapter 1. Martha’s Vineyard Community Values	40
Island Communities	40
Trade-offs Living on Martha’s Vineyard	44
Threats to Martha’s Vineyard Communities	60

Vineyarders' Efforts to Protect Martha's Vineyard's Community Life	67
Efforts to Promote Health Care Organizations Vineyard Use	83
Chapter Summary	91
Chapter 2. Vineyarders' Health Care Value Orientations	93
Utilitarian Values: Business Orientations Versus Health Care Orientations . . .	93
Sources of Alternative Health Care Rationing	96
Insurer Business Orientations	102
Health Care Provider Adaptation to Insurer-managed Care	114
Health Care that Attracts Vineyard Elites	119
RomneyCare Mandate that Individuals Bear Responsibility for Health Insurance	124
Community Efforts that Mitigated Harsh Conditions for Accessing Health Care	129
Efforts Health Care Organizations Made to Include and Exclude Vineyarders	131
Collecting Balances Due	135
Health Care Policies Diminish and Divide Communities	142
Chapter Summary	147
Chapter 3. Organization of Martha's Vineyard Health Care Providers	149
Vineyard Health Care Professional Stratification	150
Nonprofit and For-profit Martha's Vineyard Health Care Providers	165
Health Care Organization Networks	176
Networks that Helped Mitigate On-Island Geographic Barriers to Health Care	181

Martha’s Vineyard Community Health Networks	183
Chapter Summary	190
Chapter 4. Summary and Conclusion	191
Community Boundaries and What They Meant	192
Cyclical Health Care Organization and Community Relations	194
Mainland Influences on Martha’s Vineyard Health Care Organizations	202
Isolation of Those Who Could Not Afford Health Care	204
Local Efforts to Resolve Difficulties Accessing Health Care	206
Summary of Chapters	210
What This Dissertation Argued	215
Contributions to Anthropology	216
Appendix A. Interview Schedule	221
Appendix B. Glossary	262
Endnotes	271
Cited Works	278

List of Tables

Table 1. Ferry service to Martha’s Vineyard	5
Table 2. Distribution of Martha’s Vineyard down- and up-Island populations	5
Table 3. Comparison of HCC and health care professional responses to “Do you believe there are barriers to or difficulties in getting professional health care services on MV?”	10
Table 4. Percent of responses to “Do you believe that barriers to or difficulties in getting health care on MV have been caused by factors produced on-Island or by factors produced off-Island?”	11
Table 5. Percentages of study participant responses to “Are you a MV health care provider, MV health care administrator, MV health care trustee or do you hold a political office?”	27
Table 6. Percentages of clinician responses to “What is your health care profession?”	28
Table 7. Percent population growth in Dukes County from 1931-2010	43
Table 8. Responses to “How long have you lived on MV?”	43
Table 9. Responses to “Do you plan to relocate from MV?”	44
Table 10. Dukes County and Massachusetts commute times for workers aged 16 and older	47
Table 11. Percentage of occupied and unoccupied housing units in Dukes County	57
Table 12. Districts listed in town zoning bylaws, their locations, and their purposes	72
Table 13. Comparison of year-round and seasonal Vineyarders’ responses to “What do you identify as your community on Martha’s Vineyard?” among Vineyarders who identified MV social networks	82

Table 14. Ratings of new pharmaceutical products and indications between 2002 and 2011	102
Table 15. Comparisons of percent of HCCs and health care provider, trustee, and administrator responses to “Is your health insurance adequate, somewhat adequate or not adequate to meet your health care needs?”	111
Table 16. Kinds of physician practices on Martha’s Vineyard and US, time of year opened, patients per physician, and costs to join	122
Table 17. Costs per summer for Martha’s Vineyard concierge medical practice	123
Table 18. Percentage of those who claimed they had past due billing in response to “Have you or a member of your household ever had a past due health care bill from MV or off-Island health care provider?”	138
Table 19. Heavy-handed actions taken against HCCs who have had past due billings in response to “What methods did health care providers use to get payments?” compared with data provided by MVH official	139
Table 20. Criteria that define physicians’ prestige	157
Table 21. Distinctions between Advanced Practice Nurse (Nursing Practitioner and Clinical Nurse Specialist) and Physician Assistant physician extenders	161
Table 22. Year Martha’s Vineyard health care organizations opened, their tax statuses and their purposes	166
Table 23. Kinds of health care services Martha’s Vineyard mainstream health care organizations provided	167
Table 24. Locations of Vineyard health care organizations	169

List of Figures

Figure 1. Map of Martha’s Vineyard and the Elizabeth Islands 2

Figure 2. Map showing relation of Martha’s Vineyard (and Nantucket) to Cape
Cod and the Massachusetts south shore 3

List of Abbreviations

AMA - American Medical Association
APN - Advanced Practice Nurse
CAH - Critical Access Hospital
CAM - Complementary and alternative medicine
CEO - Chief Executive Officer
CNA - Certified nursing assistant
CNS - Clinical Nurse Specialist (or more generally, APN)
CPA - Community Preservation Act
DCHC - Dukes County Health Council
DCPDP - Dukes County prescription drug plan
EMT - Emergency Medical Technicians (basic, intermediate, paramedic)
FDA - US Food and Drug Administration
FPMV - Family Planning of Martha's Vineyard
HCA - Health care administrator
HCC - Health care consumer
HCT - Health care trustee
HCPTA - Health care practitioners, trustees, and administrators
Hospice - Hospice of Martha's Vineyard
HPSA - Health Professionals Shortage Area
ICD - International Classification of Diseases
IHC - Island Health Care (rural health care clinic in Edgartown)
IHP - Island Health Plan
LPN - Licensed Practical Nurse
MAG - Massachusetts General Hospital
MD - Medical Doctor (physician)
MVC - Martha's Vineyard Commission
MVCS - Martha's Vineyard Community Services
MVH - Martha's Vineyard Hospital
MVLB - Martha's Vineyard Land Bank
NP - Nursing Practitioner (or more generally, APN)
Partners - Partners Health Care
PA - Physician Assistant
PT - Physical Therapist
RHC - Rural Health Clinic
RN - Registered Nurse
SSA - Steamship Authority (Woods Hole ferries to Martha's Vineyard and Nantucket)

US - United States

VHCAP - Vineyard Health Care Access Program (VHCAP).

VNA - Vineyard Nursing Association

VNS - Vineyard Nursing Services (of Martha's Vineyard Community Services)

Windemere - Windemere Nursing and Rehabilitation Center

WTHS - Wampanoag Tribal Health Services

Introduction

Utilitarian values explain some of the issues on Martha's Vineyard and ways Vineyarders try to resolve them. "Utilitarian values" are those values that promote adherents to act on the basis of that which is expected to bring the most happiness (qualitatively or quantitatively) to either one self or the larger collectivity or group. Unlike a group or society, a collectivity is an order of individuals "who have a sense of solidarity by virtue of sharing common values" (Merton 1968:353).

Study Site: Martha's Vineyard

Martha's Vineyard, Massachusetts is a relatively isolated rural island located in the Atlantic Ocean approximately five miles off the coast of mainland Massachusetts, or more specifically, Cape Cod (Huntington 1989:1). As depicted in Figure 1, the ocean waters surrounding Martha's Vineyard are Nantucket Sound (points north and east toward Cape Cod's southern shore and toward the island of Nantucket) (shown in Figure 2 below), Vineyard Sound (points north and west toward Cape Cod's southwestern shore and the Elizabeth Islands), and the Atlantic. The Elizabeth Islands (town of Gosnold) provide a protective barrier to Martha's Vineyard's northwest shore (Martha's Vineyard Online 2017). The area of Martha's Vineyard is approximately 100 square miles (Peters 2000:A-7). Its greatest length is twenty-three miles and its greatest width, nine miles (Huntington 1989:1). Dukes County's constituents are Martha's Vineyard's six towns

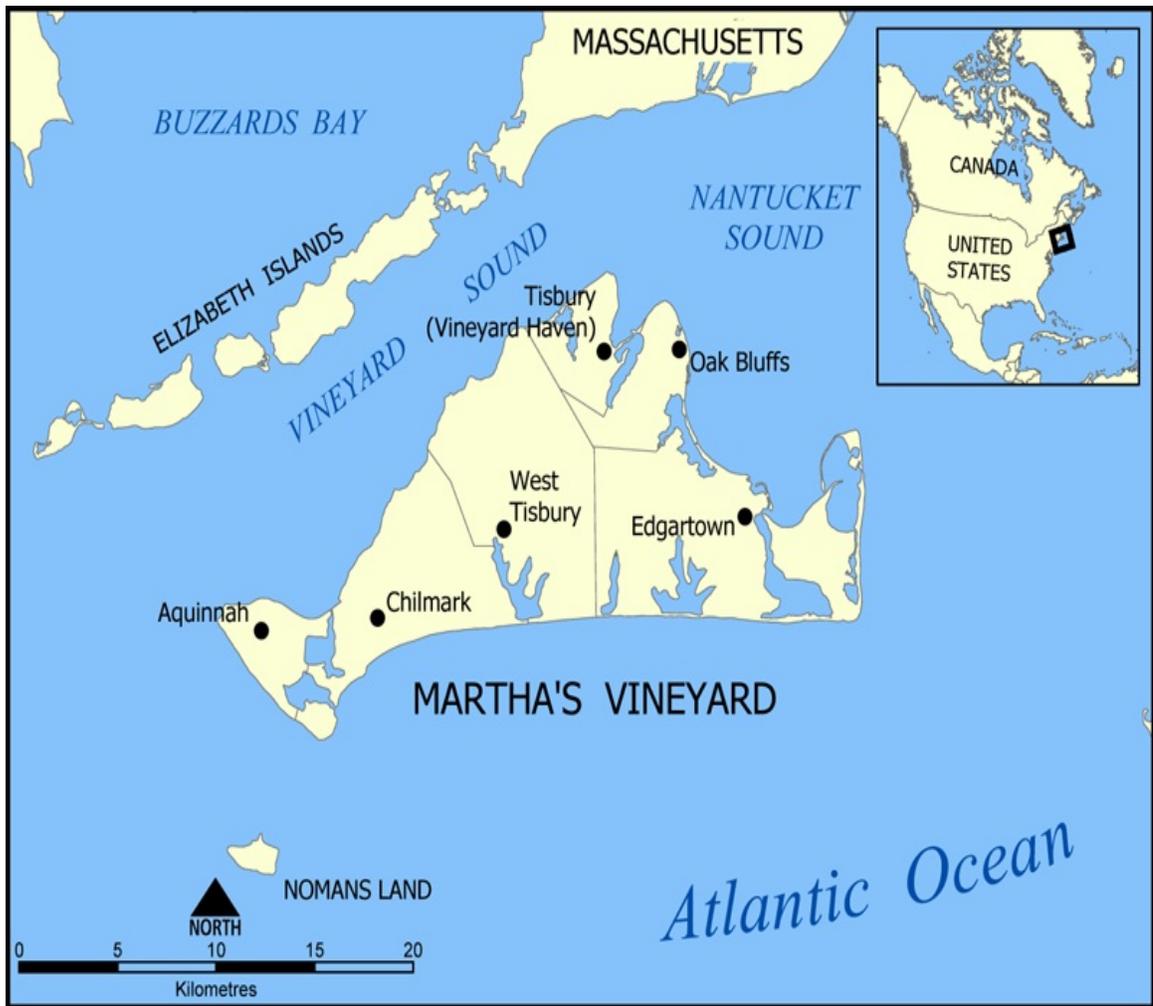


Figure 1. Map of Martha's Vineyard and the Elizabeth Islands (Creative Commons (Wikipedia 2018)).

and Gosnold (the Elizabeth Islands, shown in Figure 1). In 2000, Gosnold's population was 86. Martha's Vineyard's towns are Edgartown, Oak Bluffs, Tisbury (Vineyard Haven), West Tisbury, Chilmark, and Aquinnah.¹ Massachusetts has a "home rule provision" which means decisions made at Massachusetts town meetings cannot be overturned by the state (Bryan 2004:285; Levitan and Mariner 1980:152-153).

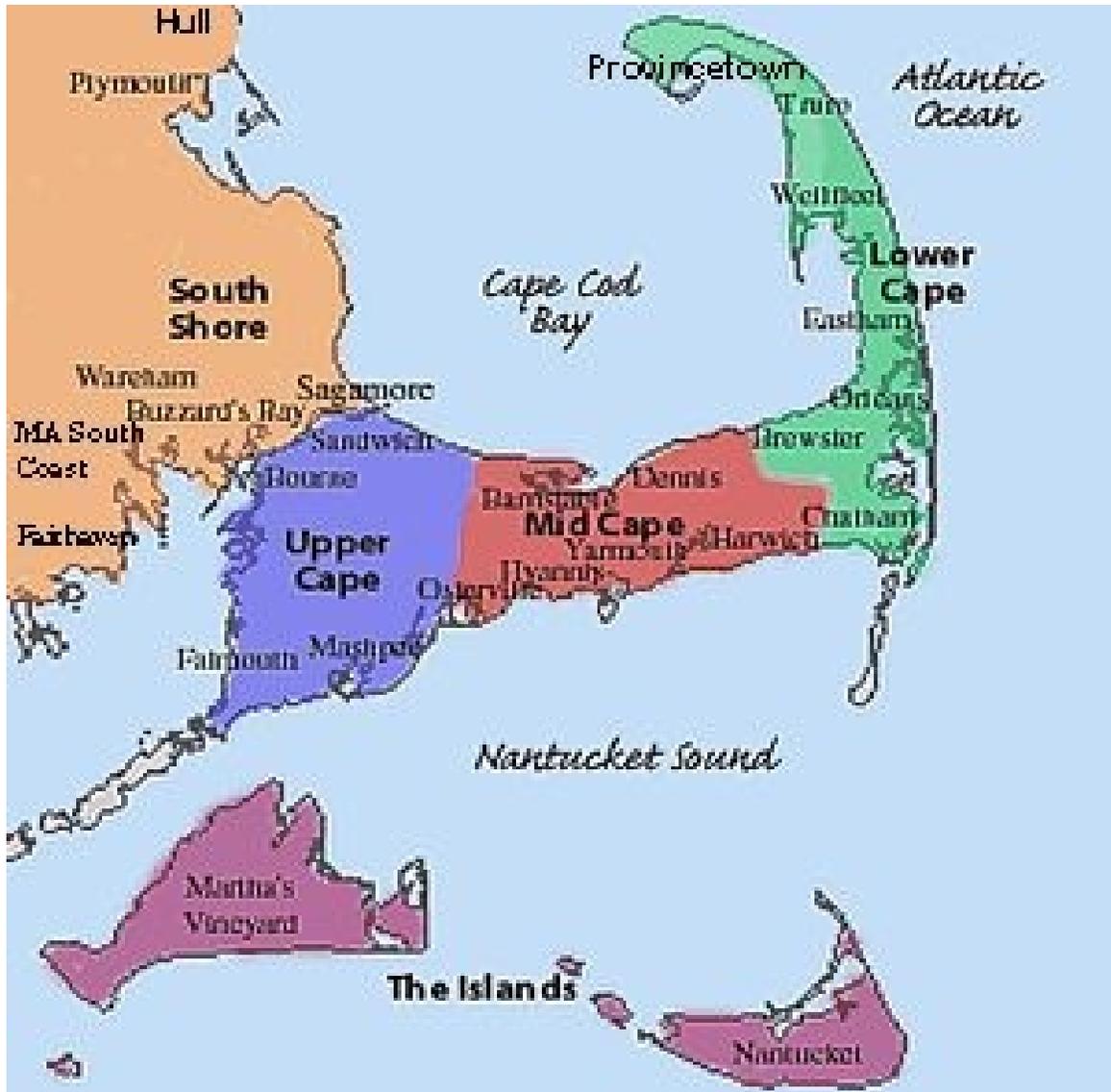


Figure 2. Map showing relation of Martha's Vineyard (and Nantucket) to Cape Cod and the Massachusetts south shore (Pinterest n.d.).

Figure 2 shows Martha's Vineyard's (and Nantucket, Martha's Vineyard's sister island) location in relation to Cape Cod and the Massachusetts south shore.

Massachusetts's bordering states are Rhode Island and Connecticut to the south, New Hampshire and Vermont to the north, and New York to the west.

Martha's Vineyard's isolation is likely what led Vineyarders to claim that their ferries were their "lifelines." Perhaps this was because Martha's Vineyard depended on the ferry for many supplies (Shuman and Hoffer 2007:2), many Vineyarders relied on the tourists (Shuman and Hoffer 2007:16) (most of whom, like Martha's Vineyard residents, traveled to the Island by ferry) to make a living, and many Vineyarders' social networks included mainlanders. On Martha's Vineyard, a "Vineyarder" denotes a local—one who lives on Martha's Vineyard. In this dissertation, a "Vineyarder" is one who lived on or visited Martha's Vineyard during a time in which this field research was being conducted (April 2006 to October 2007 and return visits) and those who lived on or visited Martha's Vineyard during historical periods being discussed.

Steamship Authority (SSA) ferries in Woods Hole (Falmouth) were the only ones that provided year-round travel and that took automobiles to the Island. Other ferries (as shown in Table 1) departed from elsewhere in Cape Cod, from New Bedford, and from Rhode Island. Most who flew to Martha's Vineyard landed at Martha's Vineyard Airport (MVA) which is located in the middle of the Island. Small aircraft used MVA, Katama Airfield or Trade Wind Airport (Reichel 2017:1-B; Stringfellow 2017:A-7).

Embarkation port	One-way travel		Auto trans.	Year-round service	Disembarkation port
	Hours	Min.			
Falmouth, WH	0	45	Yes	Yes	Vineyard Haven, Oak Bluffs
Falmouth, downtown	0	35	No	No	Oak Bluffs
Falmouth, downtown	1	0	No	No	Edgartown
Hyannis	1	0	No	No	Oak Bluffs
New Bedford	1	0	No	No	Oak Bluffs
Quonset Point, RI	1	35	No	No	Oak Bluffs

Auto trans.=if could take an automobile to Martha's Vineyard on the ferry;
Min.=minutes; RI=Rhode Island; WH=Woods Hole
Sources: Delaplaine 2014:7; Hy-line Cruises 2017; Sinai 2009:xvi-xvii; Vineyard Ferries 2017.

As Table 2 shows, a majority of Martha's Vineyard's population resided in Martha's Vineyard's three easternmost towns (down-Island). The up-Island towns become more sparsely populated as one headed west.²

Populations (down- and up-Island)	Percent of population	
	Martha's Vineyard (n=14,901)	Study participant (n=251*)
Down (Edgartown, Oak Bluffs, Tisbury)	75.5	61.8
Up (W. Tisbury, Chilmark, Aquinnah)	24.5	38.2

*One Martha's Vineyard health care professional lived on the mainland and commuted to Martha's Vineyard. Gosnold's (Elizabeth Islands) population was 86.
Source: US Bureau of the Census 2000b.

Many viewed Martha's Vineyard as a playground for the rich and famous. While several wealthy and famous people visited or owned property on Martha's Vineyard, they made up a small percentage of the population.

Travel writers portrayed Martha's Vineyard idyllically. Their descriptions were superficial because they excluded much of that which Martha's Vineyard residents experienced. Scott Phillips (1986:144) referred to such superficial descriptions as

stemming from “cultural shorthand.” For Phillips, members of a group use cultural shorthand to express themselves to outsiders (more superficially) as a homogenous and unified group (Phillips 1986:144, 149). The travel writers were outsiders who were providing the descriptions.

Travel writers’ portrayals of Martha’s Vineyard’s idealism likely attracted Vineyard visitors. Travel writers portrayed Martha’s Vineyard as a magical place to where mainlanders could escape. One wrote, “Many, many people travel from all parts of the world to the Island. The Vineyard has a magical call, and if you hear it, you will return again and again” (Mascott 1998). A *Martha’s Vineyard Life* magazine editor stated that she was awed by Grand Illumination Night that turned Wesleyan Grove (the Campground):

into a place more magical than Disney World. . . . the . . . spectacle of several hundred fancifully shaped and colored paper lanterns festooning the porches and eaves of gingerbread cottages that are huge on charm even minus added decoration. My daughter, then seven, said it all when she announced the next day that she never wanted to move from . . . Cape Cod, but if we had to, the only place she would consider relocating to would be a cottage in the Oak Bluffs Campground. . . I feel this way about the entire island of Martha’s Vineyard. There’s . . . something in the air that makes one want to stay, whether it be in the quintessential fishing village of Menemsha . . . the lovingly tended fields of the FARM Institute in Katama . . . or at a picnic table anywhere digging into a plate of local oysters (Rohlf 2007:7).

Martha’s Vineyard offered the chance to enjoy the magic “Menemsha has to offer. The seafood, beach, fishing, sights, and sunsets are among the simplest, but most magical, of pleasures” (McKeon 2007:27).

One purported that Martha’s Vineyard provided “an antidote for the doldrums” (Mascott 1998). However, the *Martha’s Vineyard Life* editor warns, “Just remember,

once you're there, it's hard to leave" (Rohlf 2007:7). Visiting Martha's Vineyard but not staying could put one at risk for "Island Attachment Disorder" (Rohlf 2007:7). One stated that "even with development taking its toll, the Cape and islands retain a certain timelessness" (Reckford 2015). Writers painted Martha's Vineyard as a social paradise where one could expect:

a sense of cooperation and the acceptance of others, regardless of differences . . . where faces are familiar and everyone knows your name . . . and where people . . . will stop and say hello, [and] help . . . when you need assistance (Mascott 1998, brackets added).

My study suggests that a surprising number of Vineyard visitors stayed on Martha's Vineyard as year-round residents. Martha's Vineyard idealism was so strong that a surprising 4.8 percent of study participants claimed they visited Martha's Vineyard and did not leave or left long enough to collect belongings and "tie up loose ends." Perhaps the percentage of those who visited and stayed would have been larger had an interview item been included to elicit such data. They had visited as visitors, as visitors to friends or as a summer visitor and stayed year-round. They planned to work only a short time but stayed. Some purchased a summer home and stayed year-round. This 4.8 percent of Vineyarders did not include summer home owners who gradually became year-round residents as they spent increasingly more time on Martha's Vineyard.

Problems that Led to This Dissertation

"While many Vineyarders viewed Martha's Vineyard as ideal (relative to mainland urban and suburban communities), they recognized that living on Martha's Vineyard entailed several trade-offs. Trade-offs such as buying power, occupational

promotions, employer-subsidized health insurance, and being far removed (physically) from some secondary and all tertiary health care centers were worth their gains. They lived in a community they liked and enjoyed Martha's Vineyard's:

moderate climate. Winters tend to be milder than on the mainland; summers, cooler. Spring comes more slowly, but autumn on the Island can be blissfully prolonged and warm compared with mainland regions of similar latitude (Hale 1988:8).

Martha's Vineyard's isolation from the mainland did not prevent its communities from experiencing problems or encountering threats. Those seeing Martha's Vineyard from a cultural longhand perspective recognized that Martha's Vineyard had significant social problems including unemployment, poverty, and psychological issues (Wells 2003:1, 12; Carpineto 1998:203-204; Allen 2005:226-227; *Vineyard Gazette* 2009b: 14-B; Berlow 2007). Cultural longhand tends to be used when insiders express their personal identities among themselves (Phillips 1986:144). Unlike cultural shorthand that tends to provide more "black and white," dichotomous distinctions, "cultural longhand" (Phillips 1986:144) tends to distinguish according to more a nuanced "placement" on a continuum, i.e., "degrees of belonging" (Phillips 1986:149).

Vineyarders most often viewed Martha's Vineyard's high cost of living as the greatest threat to Martha's Vineyard because it had forced too many Vineyarders to relocate to the mainland. This was heartbreaking if a dear friend or relative was forced to leave the Island. Also, this diminished Island communities because Vineyarders often viewed those who shared Martha's Vineyard values as integral to their communities.

Though many maximized their time working, often at multiple jobs (especially in summer), a significant number of Vineyarders either lived in or teetered close to poverty (Gay 1998; Carpineto 1998:143; Martha's Vineyard Donors Collaborative 2011). Vineyarders' average wages were estimated to be 27 percent lower than the Massachusetts average (Martha's Vineyard Donors Collaborative 2011). Its cost of living was estimated to be 15 to 20 percent (Allen 2004) or 25 percent higher than that of mainland Massachusetts's (County of Dukes County Heller Report 2006), 12 percent higher than Boston's, and 70 percent higher than the nation's (Martha's Vineyard Donors Collaborative 2011; Martha's Vineyard Commission 2007:3).

As Table 3 shows, many health care consumer (HCC) and health care practitioner, trustee, and administrator study participants recognized that barriers to, or difficulties accessing health care, existed on Martha's Vineyard. A "barrier" is a material such as a highway, waterway or some other structure that prevents actions or a nonmaterial entity such as behavioral barriers or trade barriers (Merriam-Webster Online Dictionary n.d.a). A "difficulty" is a lack of resources, such as money or ability to interpret; someone objecting to another's intended action; or embarrassment or trouble that impedes one from performing a desired action (Merriam-Webster Online Dictionary n.d.b).

Table 3. Comparison of HCC and health care professional responses to “Do you believe there are barriers to or difficulties in getting professional health care services on MV?”		
Study participant status	Do you believe there are barriers to or difficulties in getting professional health care services on MV?	
	Percent of responses	
	Yes	No
HCCs (n=125)	82.4	17.6
HCPTAs (n=100)	86.0	14.0
All (n=225)	84.0	16.0

HCC=health care consumer; HCPTAs=health care practitioners (clinicians), trustees, and administrators (health care professional)

A significant barrier to health care was that Vineyarders (and inhabitants of other small islands where there are no bridges to the mainland) risked being stranded during inclement weather if water and air transportation services were interrupted. This was inconvenient especially for critically ill Vineyarders who needed kinds of emergency health care that were not available on Martha’s Vineyard. Barriers and difficulties, as defined above, were not mutually exclusive. Some Vineyarders found it difficult to cover the financial and other costs for traversing the ocean barrier to reach mainland health care venues. For many, obtaining mainland health care services entailed losing a day at work. Logistical problems, such as those above, explain that Vineyarders (whether or not they had health insurance) often blamed factors on Martha’s Vineyard for barriers to health care³ (Table 4).

Table 4. Percent of responses to “Do you believe that barriers to or difficulties in getting health care on MV have been caused by factors produced on-Island or by factors produced off-Island?”				
Insurance status	If barriers to/difficulties in getting health care on MV caused by factors produced on-Island or by factors produced off-Island?			
	Percent			
	On-Island	Off-Island	Both	Do not know
All with HI (n=155)	41.9	10.3	35.5	12.3
All without HI (n=22)	36.4	18.2	31.8	13.6
All (n=177)	41.2	11.3	35.0	12.4

HI=health insurance

Many Vineyarders experienced difficulties accessing health insurance.

Difficulties affording health insurance and health care could be a source of shame and isolation. A study participant claimed that she felt ashamed that she could barely afford health insurance. However, she was not alone. A consultant (John Snow, Inc.) found that Dukes County’s 19 percent of residents who did not have health insurance made up approximately twice or nearly three times the Massachusetts percentage of uninsured (Moscovice and Elias 2003:2; *Vineyard Gazette* 2000a:1A; Chambala 1999:2). Seasonal employers who typically did not offer health insurance to employees (Rappaport 2008a:1; Moscovice and Elias 2003:4; Claxton et al. 2014:57) played a significant part in Martha’s Vineyard’s high rate of uninsured. Around the turn of the millennium, researchers found that at least 80 percent of Martha’s Vineyard’s uninsured were employed (Chambala 1999:2; Moscovice and Elias 2003:2). In 1999, John Snow researchers found that only eight percent of Martha’s Vineyard employers offered their employees health insurance (Chambala 1999:2). It is likely that difficulties accessing health insurance were

significant in the failure in the US (as on MV) to meet the World Health Organization's standard of:

ensuring that all people can use the promotive, preventative, curative and rehabilitative health services they need, of sufficient quality to be effective, while ensuring that the use of these services does not expose the user to financial hardship (Dao and Nichter 2015:123).

Martha's Vineyard's population fluctuations made it difficult for Vineyarders to run a business and to staff it adequately. Martha's Vineyard's population fluctuated during the tourist season (summer) when the Island's population reached as high as 90,000 (Moscovice and Elias 2003:2) to an estimated 105,624 (Martha's Vineyard Commission 1998:5). There were two shoulder seasons (early fall and late spring) when there was a smaller tourist population and off-season (late fall, winter, and early spring) when few visited Martha's Vineyard. The year-round population was 14,987 in 2000 (US Bureau of the Census 2000a).

Part-time Vineyarders tended to be wealthier than year-round Vineyarders. The annual influx of part-time Vineyarder, many of whom had more spending power than year-round Vineyarders, promoted a high cost of living on Martha's Vineyard. As discussed in Chapter 1, this led many Vineyarders to live in substandard housing, especially during summers. Fluctuations in population made it difficult also for staffing Martha's Vineyard Hospital (MVH). During August, its busiest month, MVH emergency department personnel had treated up to 64 patients a day (Lovewell 2010:1). During a winter night, this department typically treated three patients (Allen 2003). Yet, MVH was

required to staff its hospital in sufficient numbers to handle any emergency, if and when it occurred.

A longhand approach revealed, as did the literature (Burrell 2001:7), a Martha's Vineyard public health nurse and several study participants, that several mainlanders relocated to Martha's Vineyard to gain spiritual and mental respite, recover from personal tragedies (e.g., divorce and psychological breakdown), or to avoid the pressures of highly competitive, mainland communities. A longtime Martha's Vineyard substance abuse counselor, Hazel Teagan stated, "People come here, thinking it's a utopia and that all their problems will go away. . . . But they actually . . . bring their problems with them" (Burrell 2001:7). Some Vineyard psychologist study participants claimed that Vineyarders tended to experience the same kinds of social pathologies they found while practicing psychology on the mainland. Newcomers' social problems likely worsened after their sense of Martha's Vineyard idealism that had led them to relocate to Martha's Vineyard waned. Perhaps living on an ideal island made experiencing social pathologies worse because if one could not find happiness in paradise, then what further possibilities could have existed?

Teagan noted that Martha's Vineyard's isolation and its influx of people coming to heal (Burrell 2001:7) likely explained Martha's Vineyard's high levels of depression,⁴ spousal abuse, alcoholism,⁵ and drug abuse (Wells 2003:1, 12; Carpineto 1998:203-204; Allen 2005:226-227; Becker and Silberstein 2006:44, 54). Perhaps contributing factors to these high levels were having to spend much time working to "make ends meet," living in a small community where Vineyarders encountered the same people who tended to

remember one's transgressions, and being isolated because many community spaces closed each winter and the raw and damp winter weather led people to stay indoors.

Community and Values Provide Keys to Understanding

“Community” and “values” are keys to understanding how health problems are caused, mitigated, and resolved. Nevertheless, community researchers have encountered difficulty precisely defining abstract concepts such as “community” and “values.” How can a study be valid if the key unit of analysis is not defined, is defined imprecisely or arguably, does not exist? In spite of such issues, social scientists continued to study communities (Crow and Allan 1994:193) for decades (Lynd and Lynd 1937; Vidich and Bensman 1960; Warner et al. 1964; Arensberg 1968; Arensberg and Kimball 1968; Cohen 1975; Gans 1982; Cohen 1987; Gregory 1998; Putnam 2000). Researchers legitimated their imprecise definitions of “communities” because, “like ‘family’, they exist and their received meanings are lived out and acted upon” (Crow and Allan 1994:193).

Anthropology can be used to explain Vineyarders' experiences of a shared community spirit that provides people with a “sense of belonging” (Hamilton 1985:8). This was the case even though community members often defined symbols, such as “community,” differently. Anthony P. Cohen (1985:55) argued that a symbol's imprecision promoted its efficacy whereby people attribute different meanings to a symbol that unites them. Community is symbolically constructed as a system of values,

norms, and moral codes that provides community members with a shared sense of identity (Hamilton 1985:9).

Individuals are significant to communities. The social situation is, in part, determined by the person or persons with whom one is interacting (Barth 1981:122). Individuals define their social situations and take these social situations into account while they develop their orientations to action (Barth 1981:122). Individuals modify their behavior according to the presence or the behavior of the individuals with whom they interact (Barth 1981:130) or according to the social contexts of the situations (Riesman 1954:21). The social context (real or imagined) is significant in leading one to act according to one or another set of values (Riesman 1954:20). Hence, “values” is a concept that is better left defined in context of the social system being analyzed. To meet standards expected in a social situation, individuals are “practiced in the ways of the stage” (Goffman 1959:251) with the goal of “engineering a convincing impression that these standards are being realized” (Goffman 1959:251). The values of interest to this dissertation are utilitarian values.

Anthropologists have been interested in the study of values because values could give a useful systematic frame of reference for the analysis of social behavior. Frederik Barth (1969:11, 15, 35) argued that an actor could constitute one’s own, one’s group’s, or another’s identity on the basis of statuses, norms, values, or beliefs. Community members drew on their sets of values when determining whether another deserved to be included, excluded or stigmatized. Individuals were stigmatized if they possessed “a trait that can obtrude itself upon attention and turn those of us whom he meets away from him

. . . He possesses a stigma, an undesired differentness” (Goffman 1963:5). Stigmatized individuals may form encapsulated communities. “Cultural encapsulation” occurs when established social boundaries shift during a relatively short period with the arrival of a sufficiently large influx of newcomers. Such newcomers avoid being acculturated into the community. Rather, they form their own, encapsulated communities from which they may exclude those whose community they did not assimilate (Newby 1980:259).

Utilitarian Values

“Utilitarian values” are being used in this dissertation to help understand Vineyarders’ actions. They are defined as that which brings the most happiness or well-being to the individual or group. “Well-being” is “the accomplishment of socially reasonable expectations of material and emotional comfort that depend on access to the diverse resources needed to attain them” (Narotzky and Besnier 2014:S4).

Concepts of “utilitarian values” used here were borrowed from philosophy and reworked. They were derived from J. J. C. Smart’s (1972:207) distinction between “egoistic act utilitarians” and “collectivistic utilitarians” (or what Smart referred to as universalistic act⁶ utilitarians). Egoistic act utilitarians determine the goodness or badness of each particular act by its consequences for the acting individual. This dissertation defines “egoistic utilitarians” as those whose actions benefitted the individual. Marshall Sahlins (1976:vii) defined “utilitarianism” similarly to how “egoistic utilitarianism” is defined here, as individuals’ rational actions⁷ that suggest they are pursuing their personal best interests. For example, those who are employed or who

own businesses would be classified as such because their motive is to be paid or to profit. Such self-motivation does not necessarily lead to bad consequences.

Those whose rational activities harm or diminish others whether (within or outside of legal parameters) are referred to as “egoistic, exploitative utilitarians” (or “exploitative utilitarians” for brevity). Exploitative utilitarians’ actions, such as undermining another or violating social norms of decency toward another for personal gain, suggest their individual self-interest (Browne 2009:11-12). Ruthless exploitative utilitarians would commit arson, extortion, swindling a person’s life savings, or murder if doing so were to advance the agent’s interests (Shaw 1999:17). Exploitative utilitarians are exemplified also by those who benefit from advocating neoliberal policies that promote furthered income disparities, impoverishment, homelessness and difficulty accessing health care (Browne 2009:23). Exploitative utilitarian business owners may misrepresent the quality of their products or services or pay poor wages. Exploitative utilitarian employees may do substandard work or steal from their employers.

This dissertation defines “collectivistic utilitarians” as those whose rational actions benefit the collectivity or larger group. Collectivistic utilitarians who pay the costs or suffer so that the collective may prosper are altruistic, collectivistic utilitarians (or “altruistic utilitarians”). Anthropologists have exemplified altruistic utilitarian values, for example, by those who take part in “extreme gifting” or in “voluntary, one-way flows of resources from one person to another without obligations or expectations for returns” (Halperin 2009:101-102). Altruistic utilitarians work for no remuneration or other personal benefits or donate their time or money to causes that benefit others. They are, as

Ethel D. Hume described 19th century scientist Antoine Béchamp, “indifferent . . . to the lack of riches. For him, labor was its own reward, and success was defined by the results of work and not by financial profit” (Hume 2011:118).

These distinctions of utilitarianism are not mutually exclusive. They are treated here as separate categories for analytic purposes. These kinds of utilitarianism help understanding Martha’s Vineyard’s communities if they are thought of as located along a continuum. One who exhibits altruistic utilitarian values may sacrifice much or little and may benefit the collective to a greater or lesser degree. One’s self-motivated actions could benefit oneself while also benefitting larger groups. As several study participants stated, one may derive personal satisfaction while working on behalf of others. Orientations of individuals and collectivities toward action could change both across time and, as stated earlier, while interacting with different social groups or within different social situations. One may exhibit opposite extremes of utilitarian ideologies or may switch one’s “vocabulary of motives” (Mills 1940:906) on the basis of who is (or who is believed to be) judging one’s action as good, bad or of no measurable consequence.

Martha’s Vineyard Health Care Communities

Vineyarders claimed that their Vineyard health care organizations shared some of the community ideals as described above while others claimed they did not. Vineyarders often characterized their health care organizations as “health care oriented” or “business oriented.” However, as social scientists have recognized, economic (or market) behaviors and community or social behaviors (e.g., health care behaviors) tend to be included under

one matrix (Gudeman 2001:1). As Marcel Mauss noted, “exchanges cannot be sliced up into economic, juridical, religious, and other aspects” (Dumont 2013:305). An economic system is integrated or embedded within the “social relations and the concrete semiotic practices that mediate them” (Keane 2008:37). Nonetheless, the terms “business-oriented” and “health care-oriented values” are used throughout this dissertation, though it would have been more precise to refer to these as existing along a collectivistic and an egoistic utilitarian values continuum.

As exemplified on Martha’s Vineyard, people who carried out sound business practices could have used their business training to promote altruistic or exploitative health care goals. Many Vineyarders recognized that sufficient profits were necessary to the functioning of health care organizations. They also recognized that too high a focus on profiting could be detrimental to a health care organization’s HCCs and health care professionals.

Martha’s Vineyard health care administrators (HCAs) demonstrated that maintaining rational business practices was necessary to maintaining a health care organization after the newspapers had reported their failures to perform their fiduciary responsibilities. During the 1990s, high-ranking MVH administrators demonstrated their desire for the large monetary rewards their positions afforded while they neglected their business responsibilities, produced chaos, wasted health care resources, and threatened the very existence of MVH and Windemere Nursing and Rehabilitation Center (Windemere). During the 1990s after MVH and Windemere declared bankruptcy, the extent to which they had neglected their duties came to light. A journalist stated,

“hospital trustees learned just how bad the debt was when some 300 creditors stepped forward to file claims totaling more than \$10 million against the hospital” (Wells 1998b:9). Martha’s Vineyard Hospital and Windemere HCAs had not kept an account ledger (Wells 1997c:5; Wells 1997b:1; Wells 1996a:1, 9). Rather, they had produced financial statements that were derived from “unaudited guesswork” (Gentry 1999:NE4). They had filed unsubstantiated accounting reports (study participant) and relied solely on MVH’s bank statements to roughly assess their financial standings (study participant). Their inadequate record keeping precluded fundamental business practices such as consideration of comparative analyses and planning each year (*Vineyard Gazette* 1980a:9).

Martha’s Vineyard is made up broadly of two health care communities. Both mainstream (biomedical) and alternative health care communities are of interest to this study. Mainstream and alternative health care providers competed with each other, though these two sets of modalities were not mutually exclusive. Their lack of mutual exclusivity makes it difficult to define them precisely. Both relied on a resurgence of some methods and treatments 19th century medical sects used (Salmon and Berliner 1980:536, 542; Ayers 2008:3). Both encompassed a vast array of health care practices (Eisenberg et al. 1993:246; Ross 2012:6).

The literature contradicted those study participants and others who differentiated alternative and mainstream health care professionals by whether their treatments were harmless, were derived from nature (alternative) or were harsh and unnatural (mainstream). However, some products biomedical providers used were natural. Natural

products both kinds of practitioners used were not necessarily gentle (Kopelman 2002:43, 41 citing Zollman and Vickers 1999:8, Hahm, Kujawa, and Augsburg 1999, Cui et al. 1994, Good Housekeeping Institute 1998, Parasrampur, Schwartz, and Petesch 1998:1565, LoVecchio, Curry, and Bagnasco 1998:847-848) and may have been harmful (Kopelman 2002:41 citing DiPaola et al. 1998 and Angell and Kassirer 1998). For example, mainstream physicians have widely prescribed digitalis⁸ (*Digitalis purpurea*). This drug is made from the poison in the purple foxglove flower (North Carolina Cooperative Extension n.d.). Conversely, a study participant claimed that after a Vineyard alternative health care practitioner treated him (using cupping and other alternative treatments), his compromised mobility was worsened, he was bruised, and he acquired an illness that he attributed to the treatment. Cuppers pull the skin and superficial muscle layers upward with heated jars. Some make a small incision to pull out small amounts of blood (Rushall 2017). Cupping is done to promote energy flow in efforts to improve circulation, digestion, appetite and metabolism; relieve muscle spasms; and help respiratory conditions (Rushall 2017).

Complementary medicine is alternative treatments used to complement mainstream medicine. Defining complementary and alternative medicine (CAM) modalities using “residual categories” (Wolpe 2002:165), that is, excluding that which is not part of mainstream medical or hospital practices (Wolpe 2002:165; Kopelman 2002:37-38 citing Eisenberg 1998:1569 and American College of Physicians 1998:581) holds little currency because such categories change over time (Kopelman 2002:38 citing Spiegel, Stroud, and Fyfe 1998:241-247 and Zollman and Vickers 1999:8). The term

“complementary medicine” points toward biomedical providers’ long history of co-opting and bringing alternative health care modalities into the mainstream to subordinate them to the mainstream’s “arsenal of high-tech approaches” (Baer 2004:324). Thereby, they tempered their competitors (Ross 2012:1, 8, 29; Baer 2004:324, 319 citing Wolpe 2002:169; Jordon 2012:295). That \$21.2 billion brought in 1997 to CAM providers (Ruggie 2005:982, 988; Eisenberg et al. 1998:1569, 1573) caught mainstream medical interests’ attention (Ruggie 2005:982, 988). Hence, “mainstream medicine’s historic disdain for alternative medicine . . . softened remarkably” (Whorton 2002:x). By 2002, of the 125 medical schools in the US, 81 (65 percent) or more offered (and required some) courses in alternative medicine (Baer 2004:319).

What This Dissertation Argues

In this dissertation it is argued that the recurring conflicts demonstrated below could be thought of analytically as two variations along a continuum of a single value system, utilitarianism. Utilitarian values have been significantly well entrenched in American society (Talpalar 1976:193; Polleys 1997:19) and can be used to explain the development of capitalistic health care. As in the US, some private and nonprofit Martha’s Vineyard organizations’ policies suggest that these organizations promoted the common good in greater or lesser degrees.

This dissertation argues that while many of Martha’s Vineyard health care organizations were nonprofit, the majority functioned in ways similar to for-profit organizations. The literature suggests that the delineation between the public, private and

nonprofit US health care sectors had become more blurred since 1980 (Diamond 1992:198; Estes, Swan, and Associates 1993:25). Mainland (Potter 2011:3; Mahar 2006:137-138) and Martha's Vineyard nonprofit and for-profit health care organizations were operated by the same "capitalist logic" (Imershein and Estes 1996:233 citing Navarro 1986). As Mary A. Mendelson (1974:196-197) noted:

the term "nonprofit" does not mean what it would seem to mean: there are plenty of opportunities for profit in a nonprofit operation. All it means is that . . . by law [an organization] does not produce profits for tax purposes: it does not return cash dividends to its owners (Bennett and DiLorenzo 1994:25).

This dissertation looks at Martha's Vineyard "community" and Vineyarders' "health care" from the perspective of utilitarian values. This dissertation strives to demonstrate that Vineyarders weighing their actions according to their values have promoted the social and cultural conditions of Martha's Vineyard communities and health care institutions. It demonstrates that utilitarian values can be used to explain Vineyarders' health care communities while they promote and impede their community traditions and access to health care on Martha's Vineyard. Utilitarian values have been highly influential in US social policy, legal theory, and political theory (Shaw 1999:2). This dissertation provides instances of conflicts of interest not just tolerated but as established methods of doing business for some health care power brokers.

"Institutions" are patterns of social activity expected of individuals or groups. They maintain norms that shape and guide collective or individual identity, experience, and character (Bellah et al. 1991:40). Institutions provide a mechanism to socialize, define, evaluate, reward, and punish. Examples of institutions are customs such as

shaking hands; taxing and being taxed; taking part in bureaucratic regimens, corporate practices, and family life (Bellah et al. 1991:10, 11); and planning, administering, managing, delivering, and receiving health care. While individuals engaging in patterns of behavior form, maintain and change their institutions, individuals pattern and shape their behavior through institutions (Bellah et al. 1991:5, 12, 40). Institutions provide a collective context in which individuals may assert their individualism (Bellah et al. 1991:6). We form institutions and we are formed by institutions “every time we act as parent or child, student or teacher, citizen or official, in each case calling on models and metaphors for the rightness or wrongness of action” (Bellah et al. 1991:12). An institution:

gives sense and purpose to the lives of its members, enabling them to realize themselves as spouses, parents, and children. Institutions form individuals by making possible or impossible certain ways of behaving and relating to others. They shape character by assigning responsibility, demanding accountability, and providing the standards in terms of which each person recognizes the excellence of his or her achievements. Each individual’s possibilities depend on the opportunities opened up within the institutional contexts to which that person has access. Without the collective effort represented by the teams on the field, there could be no grand slams (Bellah et al. 1991:40).

Among its conclusions is that Vineyarders used their communities to explain their actions. Vineyarders framed their actions as of benefit to their communities according to their values. Hereby, Vineyarders’ values explained their inclusion and exclusion of “others” from their communities; their efforts to promote their communities; their rationally organized health care organizations that provided health care services; and Vineyarders’ organizational networks that helped to improve access to health care and further profits. Community and health care exploits and limited public assistance had led

Vineyarders to form collectivities that helped improve conditions for community members.

Relevance of Community to Martha's Vineyard

Peter Hamilton (1985:8, 9) pinpointed the relevance of “community” to an anthropological study of Martha's Vineyard when he claimed that local community relations were significant to people's lives. This was the case on Martha's Vineyard where a majority of study participants defined their communities as their social networks. Martha's Vineyard was a significant place for a study of community and of health care. Several Vineyarders claimed that their communities had provided them well. Hence, they acted on behalf of their communities to give something back. Some who were barely making ends meet lamented that they did not have extra means (time or money) to donate to community efforts. Such efforts included helping to promote and maintain Vineyarders' traditions, to improve access to health care, to improve organization of health care services, and to improve cooperation among health care competitors.

Study Methods

Methods to elicit data used in this study were varied. They included archival data, interviews, participant observation at events such as health care forums (some of which were attended before relocating to the field), town meetings, zoning board meetings, Martha's Vineyard Commission (MVC) meetings, informational events, and church services. Such observation and use of content analyses of in-depth formal interview and informal interview data, provided a close-up view of Vineyarders promoting social and

cultural conditions necessary to the organization of Martha's Vineyard health care institutions emerging as an uncoordinated mix of rationally organized, capitalist and philanthropic enterprises.

Literature that informs this work includes works in anthropology, sociology, medicine and law. It also includes popular literature such as Massachusetts and Martha's Vineyard newspaper articles, books about Martha's Vineyard and about health care, and Vineyard health care organization pamphlets. Martha's Vineyard newspapers and other sources were cited to buttress study participant statements where possible.

A good deal of Vineyard history had been documented. Hence, preliminary research produced a good deal of archival data that included town planning reports, health care studies, business listings, and organizational mission statements. Such archival data included data about Martha's Vineyard's high cost of living, Vineyarders' use of land, Martha's Vineyard's population pressure, and efforts Vineyarders made to improve access to health care. The *Vineyard Gazette* (established in 1846) and *Martha's Vineyard Times* (established in 1984) provided valuable sources of data about health care organization and community relations and about those trying to exploit or protect Martha's Vineyard land, communities, and cultures. The *Boston Globe* and *Cape Cod Times* also provided interesting perspectives on Martha's Vineyard. Archival sources also included those kept in Martha's Vineyard town halls, the Wampanoag Tribal building, each one of Martha's Vineyard town libraries, Martha's Vineyard Museum and *Vineyard Gazette* and *Martha's Vineyard Times* offices.

The arguments in this dissertation have been derived from analyses of 262 interviews (of which ten were eliminated) and from the literature. Table 5 shows the percentages of HCCs, clinicians (health care practitioners that include medical doctors, therapists, nurses, and nursing assistants), HCAs and health care trustees (HCTs) that were interviewed. Nineteen of these study participants had been, or were at the time of the interview, a town or county political office holder. Study participants living in more populated down-Island Martha’s Vineyard numbered 155 and in less populated up-Island, 96. Sample sizes used in these tables differed according to numbers of study participants who answered the question (or questions) being discussed. Only study participants who answered the relevant question (or questions) were included in each sample. This explains the different sample sizes (n) in each table.

Table 5. Percentages of study participant responses to “Are you a MV health care provider, MV health care administrator, MV health care trustee or do you hold a political office?” (n=252)	
Study participant status	Percent of study participants
HCCs (n=133)	52.8
Health care professionals (n=90)	35.7
Health care administrators (n=11)	4.4
Health care trustees (n=18)	7.1

Table 6 shows that nurses, followed by physicians, made up the largest percentages of kinds of clinicians who were interviewed.

Table 6. Percentages of clinician responses to “What is your health care profession?” (n=90)	
Profession	Percent of HC practitioner study participants
Physician (n=20)	22.2
PA or APN (n=6)	6.7
Nurse (n=26)	28.9
PT, OT or PT assistant (n=5)	5.6
EMT (n=7)	7.8
MH counselor (n=9)	10.0
Alternative HC practitioner (n=10)	11.1
CNA (n=7)	7.8
APN=advanced practice nurse; CNA=certified nursing assistant; EMT=emergency medical technician (ambulance); HC=health care; MH=mental health; OT=occupational therapist; PA=physician assistant; PT=physical therapist	

After returning from the field, the interview data were put into tables. These tables were made up of 252 rows for each study participant and a varied number of response columns. Each study participant was numbered. All study participants, including those who did not answer the set of questions remained on the table (so that responses would line up consistently when cutting and pasting). If a study participant was counted as part of the sample, the number “1” was placed (or removed if to be taken out of the count) in the first column. A “1” was entered in each row for “yes” responses and a “0” for “no” responses in the appropriate response columns. All rows besides the HCC rows would be deleted from the table if only HCCs were counted. Word Perfect’s® “Quick Sum was used to tally the responses. These large tables were used to derive the tables used in this dissertation.

Methods were devised to ascertain that the data were being entered correctly in both the large tables not shown here and the tables presented here. Each time a response

was added, the entry was double-checked. Numbers of responses were added to ascertain that they were equal to the sample sizes. Also, a column was set up to tally all “yes” and “no” responses to insure that the number of responses was the same as the sample sizes. Addition, subtraction, and percentages were checked and rechecked. Errors that were discovered were corrected.

Formal interviews (predetermined questions) and informal interviews (questions not predetermined but asked during chance encounters, and responses written after the encounters) were done to obtain data to elicit Vineyarders’ views relevant to this dissertation. Those undergoing informal interviews were informed of the purpose of inquiry and that their information could be used anecdotally in this work.⁹ Conducting structured interviews to gain an emic perspective was precluded (in part) by the researcher deciding the questions and conducting the data analyses. The interview schedule used in this study is listed in Appendix A. Data abstracted from participant observations also provide an etic perspective because a researcher chooses events in which to participate and data that are relevant. Interviews included a small number of questions about community overall. Interviews focused on study participants’ experiences using or trying to use health care, provision of health care services, and if such health care services met HCCs’ expectations. It also focused on factors that enabled study participants to gain or prevented them from gaining access to health care services.

At least one of the following criteria was necessary for requesting an interview. A Vineyarder must have used, or tried to have used, mainstream or alternative health care services on Martha’s Vineyard or on the mainland, or were currently or previously a

Martha's Vineyard health care provider, HCA, HCT or political office holder. Most who were solicited for an interview met these criteria. Data obtained from the several study participants who were eliminated from this study (e.g., because much of the interview was not completed) were used anecdotally. Two were eliminated because these Martha's Vineyard ex-patriots no longer lived on Martha's Vineyard.

Methods used to recruit study participants for interviews varied. Study participants were found at Vineyard events, while taking care of necessary business or while "taking time off." Requests were made to randomly encountered persons who lauded or criticized Martha's Vineyard health care services. Several Vineyarders whom others had recommended were solicited.

Some study participants were randomly selected. These study participants were selected from Martha's Vineyard property owners listed in the 2006 *Martha's Vineyard Times* Supplement (2006) list of property value assessments (by town). To be selected, one's telephone number had to be listed in a Martha's Vineyard telephone directory.¹⁰ This enabled soliciting interviews from a wide variety of people on the basis of their assessed property values. The listing of property values listed all Vineyarders' property values in each town.

At first, making "cold calls" to solicit interviews was considered a highly undesirable task. But making these calls became enjoyable after placing bets with myself on such matters as to how many calls it would take to obtain a "hit" or which name on the page would agree to be interviewed. As soon as the person answered the telephone, another opportunity to place a "wager" would surface. Perhaps such a wager would be

adjusted later during the conversation. Becoming more adept at “winning” such bets helped make such telephoning enjoyable. Such enjoyment would not have been achieved if it were not for the fact that only two “cold call” recipients responded with ire toward these unsolicited telephone calls. Vineyarders who declined an interview and shared some thoughts about Martha’s Vineyard health care were informed that such anecdotes could appear within these pages (with their permission).

Health care professionals were solicited for interviews at health care events. Such events included public forums, MVC meetings, and town meetings. Some HCAs and HCTs’ names were elicited from health care organization pamphlets, web sites, and at public meetings. Such health care professionals were often named in response to “Are there other people with whom you believe I should speak?” Some were telephoned at home and others at work or were encountered by chance. One of the best “fishing holes” for study participants was at MVH grand rounds. Contacts with nurses, physical therapists and certified nursing assistants (CNAs) were made during chance encounters that occurred during several visits to hospitalized Vineyarders.

Once Vineyarders agreed to be interviewed, we agreed on a time and they chose the venues. A few study participants were asked to choose a different venue from that which he initially chose. Such reasons included that a lengthy interview could have disrupted conducting business (e.g., being seated at a restaurant while other customers were waiting). While it was necessary to exercise caution in all public venues, requests to conduct an interview in MVH’s cafeteria, where people likely would have overheard discussions about health care professional colleagues, were denied. Most of the 242

study participants whose interview venues were recorded were interviewed at either the study participants' residences (102 study participants) or a work site such as an office (34), another's office (1) or some other work site (30). Many were interviewed in public places. These public places were restaurants (39), three town libraries (4), a Council on Aging (3), Tribal building (2), town halls (3), a church (1), the ferry (1), in a field (2) or a lawn (1), at the Mill Pond (1), on a store porch (4), at a beach (1) or at my residence (13).

Telephone interviews were conducted with eight study participants. Telephone interviews were limited because without eye contact, it limited our abilities to discern sarcasm and other nuances, though this disadvantage was not overwhelming. If a study participant requested one's spouse to join the interview, permission was granted. Five sets of a husband and a wife and another set (a physician and the nurse he employed) were interviewed together. Quotations cited as "field notes" were roughly verbatim.

Field research and participant observation was advantageous because methodologies could be manipulated *in situ* to maximize that which was apt to achieve the best result as the situation changed or as more knowledgeable about the population being studied is gained. This study would have been more rigorous had all study participants been randomly selected. On the other hand, it was likely that selecting those who expressed strong positive or negative sentiments toward Martha's Vineyard health care services and on the basis of recommendations was advantageous because doing so likely biased the sample toward those more interested in health care issues. Cold calls were discontinued once many health care professionals were available for interviews. After relocating from West Tisbury to Vineyard Haven some mentally ill people agreed to

be interviewed. They made it clear that the mentally ill experienced further difficulties obtaining health care compared with those with other diagnoses. This led to interviews with mental health care professionals.

A good part of the success at this interview data collection (ease at obtaining interviews, receiving much relevant data on various issues) was likely a result of Vineyarders viewing health care access as highly relevant. Before entering the field, it seemed that study participants would be doing a huge favor if they were to be interviewed. It was surprising to learn that some study participants viewed interviews as beneficial to them. Several expressed thanks for providing them interview experiences that were enjoyable, if not therapeutic. Cohen (1985:41) buttressed this when he claimed that confidential sharing could be of value therapeutically.

A limitation to interview data was that it was not necessarily the case that individuals provided reliable data (Bernard 2002:235-237; Pelto and Pelto 1978:72-73; Fowler 1984:125). However, it seemed that Vineyarders often provided reliable data. It seemed that Vineyarders provided honest responses most often. Some study participant appeared to hold back information. But rarely did it seem one was providing a response that he believed to be untrue. It appeared that knowingly untrue responses were most often made by Vineyarders who seemed to be underestimating their annual household incomes. Flaunting one's wealth tended to be socially unacceptable on Martha's Vineyard. If the topic of one's highly valued properties was raised, Vineyarders seemed eager to explain that they had inherited their properties or bought them before Martha's Vineyard property values markedly increased. Martha's Vineyard was an excellent venue

to conduct this study because of Vineyarders' thoughtful responses to interview items. Vineyarders often paused after a question. Their body language suggested that they were carefully considering their responses. Also, their explanations often were nuanced.

No two interviews were alike. As M. Estellie M. Smith (2000:76) pointed out, even individuals of a (relatively) homogenous culture differ. Pertti J. Pelto and Gretel H. Pelto (1978:72) claimed this could have been attributed to individuals' differences in kinds of knowledge gained, interpretations of such knowledge, and willingness to discuss what they know. Like Erving Goffman (1959:251), Pelto and Pelto (1978:74) argued:

Every individual . . . has a particular image of himself and his position in the world of people and things – an image he endeavors to maintain as a consistent presentation of self to fellow human beings. His verbal statements to anthropologists are affected by this tendency.

Study participants varied in their styles of providing data. Some appeared to desire responding to each question without feedback. Others appeared to desire discussions. Providing feedback was done carefully because an interviewer's behavior could affect a study participant's responses (Bernard 2002:235). Sometimes a researcher's feedback through comments such as, "that is a good idea" "I see," "that is correct" or "uh-huh" helps probe study participants for further information (Bernard 2002:212). The "echo probe" helped put the study participant at ease because it confirmed that the interviewer was understanding the study participant (Bernard 2002:212). Offering a counter point was sometimes carefully used to assess study participants' levels of commitment to their points or to ascertain they were being interpreted correctly.

Study participants provided intimate details about their encounters with health care providers, their attempts to access health care, and other issues they deemed worthy of discussion. Some interviews took very long (e.g., a total of ten hours in three meetings). Long interviews occurred largely because study participants were defining the content of the discussions (Bernard 2002:209). Study participants were not interrupted if they strayed off the topic unless it was because they had misunderstood the question. Also, this interviewer rarely, if ever, dissuaded study participants using such techniques as “gentle inattention” (Bernard 2002:215), looking away, stopping recording of the conversation or leafing through papers (Bernard 2002:215). In the context of study participants’ life situations, their wide spectrums of political views appeared to make perfectly good sense. Hence, study participants received sincere affirmation during such discussions across a wide political spectrum.

Data Analysis

This study used content analysis of people’s actions (Bernard 2002:476-477) to interpret what values Vineyarders used to inform their actions. S. Lochlann Jain claimed that our values could be abstracted from our ways of treating disease and stated:

the questions framed in various expert and lay areas, and the forms that the answers take, provide clues about the values that underpin our understandings . . . just as crude oil oozing from a pipeline onto the Arctic snow discloses the dominant values of the society that laid the pipe (Jain 2013:14).

Sidney Willhelm used content analysis of arguments and argued that zoning board members decided on the basis of their own and others’ value orientations whether to require maintaining or to allow changing the kind of land use of the parcel under

question. Willhelm argued that Austin, Texas zoning board members defined the social situation according to norms or standards “of expectation for social conduct to be approximated or actualized in performance” (Willhelm 1962:36). In defining these norms, they used “a set of interrelated values” (Willhelm 1962:84) and made decisions about zoning through “the implementation of social values, or social value systems” (Willhelm 1962:84-85). Actors gave interpretative significance to the stated goal, social conditions, and cognitive data involved in the zoning process. Then they selected a norm from the several possible alternatives that constituted one or more means for accomplishing an objective (Willhelm 1962:84-85). Such action appeared to be played out at Martha’s Vineyard town meetings as well. Sentiments about one’s standing in the community tended to hold a good deal of weight when a project was being voted. A land owner’s willingness to mitigate its negative impacts to neighbors, towns, users of the space, or Martha’s Vineyard communities was significant to increasing the chances for the project’s approval.

Data were not used that could have embarrassed study participants or promoted ill relations with their employers even for those few who claimed such data could have been used. To help maintain confidentiality, general terms such as “official,” “study participant,” “health care professional” or “Vineyarder” were used in some instances rather than a more specific occupational title (e.g., nurse, psychiatrist). Also, though a larger percentage of study participants were females, “he” was used as a pronoun in some instances to refer to female study participants and to refer to all health care professionals (besides nurses). In 2008, 93 percent of nurses were women (McHugh et al. 2011:207

citing US Department of Health and Human Services 2008). All nurses and the very small number of physician assistants (PAs) were referred to as “she” irrespective of their genders. This was necessary to maintain confidentiality for these males and PAs given their small numbers on Martha’s Vineyard.

It is not a researcher’s task to achieve a consensus among all study participants if they were to read the study. Rather, a researcher’s task is to present interpretations of data within the scope of the study. People of a single community, if there is such a thing given that community inheres in the minds of individuals, tend to hold a wide variety of perspectives, order their priorities and interpret phenomena in their unique ways differently, and respond differently to similar events. It is likely that Vineyarders would hold a wide variety of sentiments about this portrayal of Vineyarders’ portrayals of Martha’s Vineyard communities. Though “ethnographic writing cannot entirely escape the reductionist use of dichotomies and essences, it can at least struggle self-consciously to avoid portraying abstract, a-historical ‘others’” (Clifford 1983:119 citing Said 1978). We need not lament the unreachable inter-rater reliability that would have been necessary for a common “truth.” Such truth was neither possible nor desirable. James Clifford (1983:119) further added that:

It is more than ever crucial for different peoples to form complex concrete images of one another, as well as of the relationships of knowledge and power that connect them. But no sovereign scientific method or ethical stance can guarantee the truth of such images.

If such a truth were to reign, social scientists would be rendered obsolete and interest in social phenomena would soon be exhausted if all were to understand these phenomena in

the same way. Rather, readers must consign themselves to passenger seats while the ethnographer steers.

Order of Chapters

Chapter 1 argues that Vineyarders valued their communities so much that they made some significant trade-offs to live there. Their community idealism led them to trade quantifiable resources (e.g., cash flow) for qualitative prosperity. Threats to one's community led Vineyarders to embrace their communities more tenaciously. They formed collectivities to prevent or mitigate threats to their sense of Martha's Vineyard community ideals. Such collectivities formed utilitarian solutions that benefitted either collectivities or individuals.

Chapter 2 argues that actions by health care professionals and by health care organizations suggested that some Vineyarders were viewed as deserving of generous health care benefits while others as deserving to have their health care rationed to greater or lesser degrees. Insurers had promoted a fragmented, costly health care system that often served those patients who needed health care services the least while leaving those who needed them most to fend for themselves. Some Vineyarders received an abundance of health care. Others were not able to gain access to basic or emergency health care. This study found that the exclusion from health care communities (explicitly or implicitly) promoted isolation and divisiveness on Martha's Vineyard.

Chapter 3 describes the organization of Martha's Vineyard health care organizations. Here, the term "organization of health care" is the rigid hierarchy of

dominance and subordination of Martha's Vineyard health care professionals and the roles Martha's Vineyard health care professionals were required to perform. Chapter 3 outlines the orders of prestige that people had attributed to different health care occupational positions. This chapter argues that Vineyarders who formed business networks tended to be motivated by Martha's Vineyard's isolation from health care services and their hopes to capture larger profits. It describes the business networks with local and mainland health care organizations. The conclusion of this dissertation discusses what was learned by this research and why it is important.

Chapter 1. Martha's Vineyard Community Values

This chapter discusses some of the meanings Vineyarders attributed to their communities, community attributes that they valued, threats to their communities and efforts they made to resolve such threats. Vineyarders claimed that communities they shared included the Martha's Vineyard community overall; those with whom they networked; those with whom they shared occupations or interests; and those with whom they shared space (e.g., neighborhood, town or street). Such communities were not mutually exclusive. For example, staunch members of Democratic and Republican party communities could share a tennis community. Threats to the Island's communities included Martha's Vineyard's high cost of living, scarcities of housing, limited occupational opportunities, forced relocations to the mainland, limited access to health care, and over development. Vineyarders viewed some threats as stemming (real or imagined) from the mainland (e.g., not allowing rooster ownership in residentially zoned areas) and others as endemic to Martha's Vineyard (such as petty infighting).

Island Communities

Cohen (1985:19) argued that island community members imputed symbolic meanings to the ocean boundaries that separated their islands from elsewhere. Martha's Vineyard study participants, writers and speakers often imputed their individual and collective symbolic meanings of Martha's Vineyard's ocean boundary. For Vineyarders,

this natural barrier was a significant factor among those that symbolized *the* Island's cultural distinctiveness.

Like other island inhabitants (Savory 2000:11), Vineyarders often held that the ocean boundary separated them from "the rest of the world" (Savory 2000:11) and protected them from undesirable outside influences (Savory 2000:11). Some Vineyarders claimed that the retreating glacier that separated Martha's Vineyard from the mainland approximately 21,000 years ago (Dunlop 2012:7) was one of the most significant events on Martha's Vineyard. Tom Cahill's (of Newfoundland Canada) folk song, "Thank God We're Surrounded by Water" goes, "The sea, oh the sea, the wonderful sea, Long may she roll between people and me." If a Vineyarder had written this song perhaps it would have gone "The sea, oh the sea, the wonderful sea, Long may she roll between *the mainland* and me" (Tucker 2010). Vineyarders who held Martha's Vineyard as unique claimed that *their* Island was separate from "the real world" (Wells 1999a:6 quoting Vineyard physician J. Brakoniecki; Carpineto 1998:28, 47, 53; Dutton 2004:14). Vineyarders often viewed their lives as possessing a good deal of quality compared with the lives of mainlanders, especially those in mainland urban and suburban areas.

Like other islands, Martha's Vineyard's isolation helped Vineyarders to maintain a sense of their slower pace (or as Laurie Brinklow (2013:39) put it, "pared-down lifestyle") relative to other communities, and their unity, uniqueness, other worldliness, community ideals, community intimacy, connectedness, and spirit of cooperation. Such other islands included the British Shetland Island of Whalsay (Cohen 1987:89, 100, 109; 142), the North Atlantic Canadian Grey Islands and Fogo, and some South Pacific islands

including Bruny (off Tasmania) (Brinklow 2013:39, 40, 47). Martha's Vineyard's relative isolation protected Vineyarders, to some extent, from extreme manifestations of crimes and some other social problems. Also significant was Vineyarders' sense that "all eyes are watching" and that people tend to remember another's failures and errors that promoted Vineyarders' sense of accountability for their actions.

Cohen (1985:98) argued that "community" inheres in community member thought. This dissertation views "community" as something that is not "real" except in the minds of those who believe it exists. Perhaps many Vineyarders would have agreed with W. I. Thomas's statement that people believe "community" is real hence, "it is real in its consequences" (Hamilton 1985:8). Michael Wild, a late and well-known Vineyarder, pointed toward Martha's Vineyard's idealism when he stated, "A lot of these attitudes might be called fantasy but they have practically produced the in-migrant population of the last twenty-five years" (Allen 2005:161). Some study participants and other Vineyarders stated that Martha's Vineyard's beautiful landscapes drew them to Martha's Vineyard and "the Martha's Vineyard community" led them to stay. Table 7 shows that since 1931, Dukes County's consistent population growth was interrupted only around the World War II period.

Table 7. Percent population growth in Dukes County from 1931-2010	
Decade	Percent population growth
1931-1940	14.5
1941-1950	-0.6
1951-1960	3.5
1961-1970	4.9
1971-1980	46.2
1981-1990	30.2
1991-2000	28.8
2001-2010	10.3

Source: Martha's Vineyard Commission 2013, Part 1:17-18 citing US Bureau of the Census 2010 and Town Clerk records.

Table 8 may suggest that a majority (about 80 percent) of study participants held Martha's Vineyard community life in high regard (or may suggest other factors) given that they had been on Martha's Vineyard for at least ten years.

Table 8. Responses to "How long have you lived on MV?" (n=237)	
Length of time on Martha's Vineyard	Percent of study participants
2 years or less (n=11)	4.6
3-4 years (n=7)	3.0
5-6 years (n=10)	4.2
7-9 years (n=16)	6.8
10-19 years (n=50)	21.1
20 or more years (n=143)	60.3

As Table 9 shows, a majority of study participants (73.1 percent) claimed that they did not plan to emigrate from Martha's Vineyard. It is likely that a significantly smaller percentage of Vineyarders would have considered emigration had Martha's Vineyard's cost of living been similar to the costs of living in the mainland places they were considering.

Table 9. Responses to “Do you plan to relocate from MV?” (n=227)	
If plan to relocate	Percent of study participants
Yes (n=47)	20.7
No (n=166)	73.1
Do not know (n=14)	6.2

Vineyarders who held different definitions of “community” or “ideal community” took part in harmonious social relations provided their actions did not threaten another’s community. Malleable and versatile (Cohen 1985:18) symbols, such as “community,” that lack precision are effective because they “are imprecise” (Cohen 1985:21). “People of radically opposed views can find their own meanings in what nevertheless remain common symbols” (Cohen 1985:18). Imprecise uses of a shared symbol enable individuals to use symbols “without subordinating themselves to a tyranny of orthodoxy” (Cohen 1985:21). This enables one to maintain one’s individuality while interacting within a group. The use of such common symbols promotes harmonious social relations because it enables individuals to reach surface agreements (Cohen 1985:18, 109). It is likely such efficacy helped to promote the sense of community idealism that Vineyarders often shared.

Trade-offs Living on Martha’s Vineyard

Data derived from interviews, participant observation and archives, portrayed Vineyarders as willing to sacrifice easy access to a wide variety of places for health care, entertainment, purchases at lower prices, and all else that mainland Massachusetts offered. They viewed such “trade-offs” (Kildegaard 2004:9) as worthwhile. They gained autonomy from a wide range of undesirable influences such as mainland pressures and

visits from disagreeable mainland family members. They held Martha's Vineyard's communities to be relatively ideal. They gained a quality of life in communities that they loved and that they believed were more safe, more intimate, more open toward "others" and more socioeconomically diverse¹¹ than the mainland communities they knew (real or imagined). Some Vineyarders claimed that either they or someone they knew felt overwhelmed when visiting unfamiliar mainland places populated by unfamiliar people who did not know them.

Several Vineyarders likely would have agreed with travel writers who depicted Martha's Vineyard ideally as a "refuge in an ever-changing world" (McKeon 2007:27). On this refuge, one is surrounded by "some of the most beautiful beaches in the world" (Reckford 2015). Travel writers depicted mainland stressors with statements such as that one could be "worlds apart from the frenetic tempo of modern life" (Mascott 1998) "on a pristine seashore looking out at the churning Atlantic Ocean, and putting all of America behind" (Reckford 2015). Such a sense of refuge could occur immediately:

Once you step off the ferry or airplane and head out of the town centers, you feel as if you truly have escaped from the mainland. Tranquil sanctuaries, picturesque ponds, and miles of bike paths encourage a "get-away-from-it-all" experience (Sinai 2009:xv).

While some Vineyarders would have agreed with Sinai who needed to go outside Martha's Vineyard's town centers, others included Martha's Vineyard's town centers within Martha's Vineyard's refuge.

Vineyarders held their slower pace of life compared with mainland communities in high esteem. Parents complained when a West Tisbury School principal tried to

require school children to be punctual (Pace 2005:74-75). Vineyarders suggested that they valued their slow-paced travel on familiar Vineyard roads when they rejected proposals to modernize and reconfigure roads and change traffic patterns to make automobile travel more efficient. Some Vineyarders rejected paving Tea Lane (Grossman 2005:8). Martha's Vineyard's narrow dirt roads, such as Tea Lane, slowed drivers and provided opportunities to be good citizens. Narrow dirt roads offered Vineyarders chances to show courtesy when they made way for another driver. Also, on paved roads, Vineyarders took turns proceeding at stop signs even when traffic was dense.

The Oak Bluffs Library's conference room was filled during a public meeting in 2006 about a proposal to build a roundabout.¹² Vineyarders shared their sentiments in letters to the editors such as one who wrote, a "roundabout represents Somewhere Else, somewhere we don't want to be, somewhere with aesthetic eyesores, like roundabouts, that represent the 'real world'" (Dutton 2004:14). Traffic lights could be another sore point. A retired, longtime Vineyard physician claimed that placing a single traffic light on Martha's Vineyard's quaint roads would bring to Martha's Vineyard "a 'mainland' perversion of island life — unthinkable" (Hoxsie 2004:53).

Census data shows that, unlike their mainland Massachusetts counterparts, Vineyarders had shorter commutes (shown in Table 10) on narrow, one lane (each way) scenic roads whose speed limits did not exceed 45 miles (72 km) per hour. Mainland Massachusetts's highest posted speed limit was 65 miles (104 km) per hour (Commonwealth of Massachusetts Registry of Motor Vehicles 2014:80). Friendly social relations promoted Vineyarders moving at a relatively slow pace and rarely exhibiting

impatience. Conversely, travel at a slow pace promoted friendly social relations. All Vineyarders had to resign themselves to the ocean’s will and accept that during heavy storms, they could not leave or return to Martha’s Vineyard. Some Vineyarders claimed that they grew weary of such difficulties and the planning necessary to scheduling travel to and from the mainland.

Table 10. Dukes County and Massachusetts commute times for workers aged 16 and older		
Length of commute (minutes)	Percent of commuters	
Minutes	Dukes County n=6,841	Massachusetts n=3,005,333
Less than 15	57.6	27.2
15-29	32.0	33.3
30-44	5.6	21.1
45-59	1.2	9.2
60-89	1.3	6.7
90+	2.4	2.5

Source: US Bureau of the Census 2000d

Vineyarders claimed Martha’s Vineyard’s connections to land and sea and Martha’s Vineyard’s hippie legacy helped to stem competitive relations and to maintain Martha’s Vineyard’s pared-down lifestyle. Vineyarders’ connections to the land and sea were clearly visible. Vineyarders promoted farming and maintained Martha’s Vineyard’s farmlands, ancient trails, and conservation lands. Vineyarders tried to maintain traditional uses of their harbors. They promoted the use of Vineyard Haven Harbor to dock tall ships, Menemsha Harbor as a fishing port, and water surrounding Martha’s Vineyard for the sailing of yachts and an annual regatta. While farms made up a significant part of the landscape and fishing boats docked at Menemsha Harbor, the 2000 census showed that only 109 Dukes County residents (1.4 percent) made a living in the

agriculture, forestry, fishing, hunting, and mining industries (US Bureau of the Census 2000c). The small percentage of Dukes County residents who made their livings in these industries made up three and a half times the percentage in these industries compared with Massachusetts residents (0.4 percent). Fishing was, as MVC's Economic Development and Affordable Housing Planner, Christine Flynn put it, "part of our character, it's part of our heritage. . . . It's a trademark for the Vineyard" (Kinsella 2005:5).

Anthropological tools enable one to interpret a particular community and to recognize factors that have promoted the cultural ethos of that community. George A. Theodorson and Achilles G. Theodorson (1969:93) defined "cultural ethos" as "the predominant ideas, values, and ideals of a culture or subculture which give it its distinctive character." While not all Vineyarders subscribed to a hippie ethos, such an ethos had impacted Martha's Vineyard. Several study participants and Vineyard journalist, Ivy Ashe (2013b) noted that the impact of the 1960s and 1970s "hippie invasion" of Martha's Vineyard by counterculture, young adults was still felt. Dominika Ferens noted that in the US, the hippie "cultural transformation" (Ferens 2010:137):

profoundly affected Americans' attitudes towards the environment, the body, human subjectivity, race, gender, and sexuality. As the last Vietnam War film reels flickered on televisions [sic] screens, radically-minded young (mostly white) people were moving back to the land and setting up thousands of hippie communes; they extolled healthy foods over Campbell's canned soup, relative austerity over consumerism, the hand-made over the mass-produced, and face-to-face relations within small communities over the impersonal relations that prevail in postindustrial societies (Ferens 2010:137).

On Martha's Vineyard, the hippie legacy promoted harmonious relations, world peace, land conservation, and sustenance from the land (Ashe 2013b:1, 6, 7). Members of Martha's Vineyard's artist community may, as Ashe (2013b:1, 7) claimed, have been an outgrowth of the Island's hippie legacy. Like other islanders (Brinklow 2013:39, 40, 47), Vineyarders' boundedness, connectedness, sense of isolation and sense of community drew artists. Also significant is that Vineyarders tended less often than their mainland counterparts to make invidious comparisons. An "invidious comparison" is when people take part in "a process of valuation of persons in respect of worth" (Veblen 1994:34). For example, unlike mainland Americans, Vineyarders often avoided casually asking others to what occupational statuses they belonged (*Vineyard Gazette* 2012:5). Vineyarders focused more on one's contributions to one's community.

Two physician study participants claimed that they relocated to Martha's Vineyard for its more relaxed pace (compared with the mainland's) of providing health care. With an easier workload,¹³ Vineyard health care professionals could practice more personalized medicine on patients they knew (provided the physician stayed long enough). Also, unlike suburban and urban areas and rural areas where physicians commuted long distances, a Vineyard physician may have shared the same community with a patient and may have encountered a patient outside of a health care context. A longtime Martha's Vineyard obstetrician captured this when he wrote:

I . . . started working in . . . 1982. Some of my first deliveries . . . graduated last year . . . This class . . . represents my first full year of babies delivered on Martha's Vineyard . . . We had about 140 deliveries that year . . . I just wanted to pause and reflect on the significance of this moment—my first graduating class. So many of the names are familiar to me. Throughout the years I have marveled at the names and at the children attached to these names—at your artwork hanging in school hallways, at choral concerts, at plays, at Little League, at dance recitals, at ice skating shows, at high school games and now at graduation. I always will marvel at the passage of time and at the process of growth, development and maturity.

It is a very special relationship I have shared with those of you I helped to deliver. It is one I treasure as an honor and a privilege . . . I feel almost as though you are part of my family. It is one of the unique aspects provided us by our small Island community, allowing us this kind of special relationship (Lew 2001:6).

Like US physicians who tended to be motivated to work less hard if salaried (Madison 2005:44), an MVH physician claimed that Vineyard physicians viewed being salaried (Sabatini 2002b:1) as desirable. It provided physicians an incentive to work at a more relaxed pace and to focus on practicing medicine rather than on the fiscal aspects of medical care. While many Vineyarders of various occupations worked longer hours than mainlanders, they tended not to be pushed into performing at peak efficiency. Vineyard physician James Brakoniecki claimed:

The expectations of how hard you have to work to maintain a system are far lower here than you would see in a more competitive environment. Most of the medical staff, nursing staff and ancillary staff are functioning at about 75 percent of what the real world does in terms of the workload (Wells 1999a:6).

Though not included as an interview item, two Martha's Vineyard HCA, eight Martha's Vineyard physician and six Martha's Vineyard nurse study participants buttressed Brakoniecki's statement.

Perhaps the above did not invalidate statements made by Vineyarders who claimed that Vineyard physicians did work hard. A health care administrator claimed that

MVH physicians worked four days per week and provided overnight on-call coverage every nine days and weekend coverage every ninth weekend. Before the late 1990s when Managed care insurers arrived on Martha's Vineyard (Wells 1999b:6-B), Vineyard physicians were likely working at a more relaxed pace than today's. A Martha's Vineyard physician office nurse claimed that Managed care incentives were responsible for physicians reducing the time used on each patient visit. Also, as discussed in Chapter 2, insurers promoted frustration for physicians, nurses, and HCCs in the US and on Martha's Vineyard.

As some HCCs, Vineyard physicians, other Vineyard health care professionals and the literature (Brownlee 2012; Haas et al. 2014; Oaklander 2015) pointed out, physicians working at a more relaxed pace tended to benefit their patients. Martha's Vineyard's more relaxed health care community provided physicians more time to converse with patients, uncover more detailed sets of health related issues, and more accurately diagnose. It also helped to promote good health care provider and patient relations.

A sense of Martha's Vineyard communities being less competitive was not shared by those who had lived in mainland communities (e.g., a Hawaiian community) that they believed were more laid back than Martha's Vineyard's and by some Martha's Vineyard HCAs. These HCAs claimed that the scarcity of HCA positions led them to fiercely protect their occupational positions and their occupational turfs. Some stated it was lonesome at the top of their organizational hierarchies. Some Vineyard HCAs claimed that such competition motivated them to avoid sharing information about the challenges

they faced. Also, like mainland volunteers (Wellever 2004:234), some Vineyard health care organization officials claimed that some were motivated to join the Dukes County Health Council (DCHC) to learn about their colleagues and about competing health care organizations.

Vineyarders often enjoyed the traditional, rural community values and informal labor exchanges, trust, and neighborliness that Jackson-Smith (2003:312) described. Several small, honor system businesses existed within easy access from some Vineyard roads and bike paths. Vineyarders appreciated that business owners trusted them to pay for purchases at unmanned lemonade (Louison 2000:1-A) or farm stands (Mitchell 2006:6). They claimed, as Ellinor R. Mitchell (2006:6) stated, that such trust is “part of what makes the Vineyard what it is.” Vineyarders demonstrated their trust toward others when they kept their automobiles unlocked (*Vineyard Gazette* 2009b:14B). One claimed he felt insulted when he noticed that my automobile had been locked while parked on his property. As participant observation showed, some left their keys in their automobiles. Many Vineyarders did not lock their houses (*Vineyard Gazette* 2004a:14; *Vineyard Gazette* 2009b:14B; Gay 1998; Carpineto 1998:140). Some allowed their friends, neighbors and family members to enter their homes without knocking or while the residents were not at home.

Examples of significant efforts Vineyarders made to return lost things include one who found a wallet and turned it over to a police officer who returned it to its owner (DeWitt, DeWitt, and DeWitt 2013:A-8). Also, bank employees placed a newspaper advertisement to locate the owner of a wedding ring they had found at their bank two

years previously (*Martha's Vineyard Times* 2007:31). Letter writers to a Vineyard newspaper editor expressed an appreciation toward one who returned a lost check (Abbot 2005:23) and toward one who returned a lost wallet (Hale 2006:29). A newspaper reported that a Vineyarder who scratched a parked automobile located the owner's name and asked an employee to page the owner so that she could inform him that she was responsible for the damage (Ronan and Ronan 2011:10).

Walter Goldschmidt (1978:202) and C. Wright Mills and Melville Ulmer (1946:22-23) found that residents of communities where many small businesses existed enjoyed a better quality life and living standard than community residents where large firms whose owners lived elsewhere tended to dominate¹⁴ (Lyson 2004:64-67; Lyson 2006:1002-1003 citing Tolbert, Lyson, and Irwin 1998:402-403 and Blanchard and Matthews 2006; Lyson and Tolbert 2003:228). Goldschmidt (1978) attributed a higher quality of life and improved living standard, in large part, to small farming communities' less exploitative employer-employee relations (Lyson 2004:68; Lyson 2006:1017).

Vineyarders' thriving local economies differed from many mainland economies where industrialization and urbanization had undermined local markets and had weakened local economies. Few corporate chain retailers located on Martha's Vineyard. A "corporation" is a "group, . . . collectivity, or . . . association of individuals joined by a common purpose and often endowed with special rights or privileges" (Robinson 1999:13-14). This, as several Vineyarders stated, contributed to Martha's Vineyard towns possessing their individual characters. This lack of corporate chains contributed to Martha's Vineyard's intimate business communities because it provided more

opportunities to conduct business with people one knew. It provided more small business entrepreneurial opportunities for local Vineyarders. It enabled proprietors to tailor their businesses more specifically toward Vineyarders. Such local economies could be thought of as “Up-close . . . local and specific, constituted through social relationships and contextually defined values ” (Gudeman 2001:1). Large corporate business communities could be thought of as impersonal, far away, and removed from the local social context (Gudeman 2001:1).

Participant observation and discussions with Vineyarders led to findings about structural conditions that sociologists had found in US business communities. Significantly, small business ownership promoted taking initiatives, behaving responsibly and participating in and performing leadership roles in civic organizations (Lyson 2004:66, 76 citing Mills and Ulmer 1946 and Goldschmidt 1978). The ownership of a business had provided people with a stake in their communities’ social and economic welfare. Conversely:

in an economy dominated by large corporations an individual’s engagement with the civic affairs of the local community is tempered by his or her allegiance to the corporation. When a choice must be made between what is good for the company and what is good for the community, the company’s priorities almost always trump those of the community (Lyson 2004:76 citing Mills 1951 and Whyte 1956).

Several Martha’s Vineyard HCAs viewed working in their relatively small organizations as beneficial because, unlike in a large organization, their impacts were noticeable (by themselves and by others). Some enjoyed the face-to-face contact that their small organizations enabled. They could walk a short distance to a coworker’s office rather

than using the telephone. Reasons such as these promoted the belief that Martha's Vineyard was an ideal place to live, work, and raise a family.

Once "reality" set in, Vineyarders often tempered their cultural shorthand perspectives about Martha's Vineyard. A cultural longhand perspective enabled one to understand that Vineyarders experienced similar kinds of problems that inhabitants of other small islands tended to experience. Such problems included a higher cost for goods and services (Cohen 1987:103), economically-forced emigration of Vineyard natives (those born on Martha's Vineyard) and other Vineyarders, a lack of affordable housing, threats to an adequate water supply, difficulties with sewage disposal, environmental degradation, issues stemming from a dependence on tourism and the ensuing seasonal economies that brought "feast and famine," and difficulty accessing adequate health care (Savory 2000:11).

A longhand perspective of Martha's Vineyard enabled newcomers and others to "see" Martha's Vineyard's social problems and difficult sacrifices necessary for many Vineyarders to live on Martha's Vineyard. Such sacrifices included reduced purchasing power, fewer occupational opportunities, fewer opportunities for upward occupational mobility, less spending power, and less comfortable living conditions. Vineyarders' strong commitments to being a part of Martha's Vineyard's communities and living within Martha's Vineyard's beautiful natural surroundings led them to sacrifice significant amounts of quantitative wealth (some to the extent of living in poverty) for qualitative wealth. Many Vineyarders claimed they viewed the high costs of housing as Martha's Vineyard's most pressing problem. Housing costs were estimated to be nearly

two times the national average and 13 percent higher than Boston's (Martha's Vineyard Commission 2007:3). In 2000, the median value of an owner-occupied housing unit in Massachusetts (\$185,700) was 3.8 times the medium household income. In Dukes County, the cost of the median value of an owner-occupied housing unit (\$304,000) was 6.67 times the median household income (US Bureau of the Census 2003:173). Only those few wealthy Vineyarders, those who inherited their housing, and those who purchased housing before costs skyrocketed were exempt unless they experienced difficulties paying their property taxes (given their high property assessments).

Vineyarders viewed Martha's Vineyard's high costs of housing as significant because, as discussed in the introductory chapter, it forced those who were integral to Martha's Vineyard communities to relocate to the mainland. This problem was significant also because many Vineyarders lived in inadequate housing while, as Table 11 shows, a significant percentage of housing units were vacant (56.7 percent) before the summer season resumed. Newspaper articles and study participants claimed and participant observation showed that a scarcity of affordable housing led some year-round Vineyarders to rent basement apartments with no windows; rooms with no kitchens; or apartments with poor ventilation, poor (or no) plumbing or mold issues (Tumin 2012:6; Ferdinand 2000:C-8). Dan Cabot (2005a:4) defined "affordable housing" as housing that cost no more per year than a third of the annual household income. This third included mortgage costs, home maintenance and utility costs, and taxes (Cabot 2005a:4).

Table 11. Percentage of occupied and unoccupied housing units in Dukes County (n=14,836 housing units)	
Occupied housing units (n=6,421)	Vacant housing units (n=8,415)
43.3	56.7
Source: US Bureau of the Census 2003:141; Martha's Vineyard Commission 2006:3	

An estimated 29 percent of Martha's Vineyard renters endured "the Vineyard shuffle" (Tumin 2012:1 citing Martha's Vineyard Commission 2009:16; Martha's Vineyard Donors Collaborative 2011; Garfinkel 2012; Hull and Elvin 2014:6; Ferdinand 2000:C-8). Few Vineyarders claimed that shuffling (relocating twice a year) provided a welcome change of scenery and chances to increase their social networks (Tumin 2012:6; Garfinkel 2012). Housing locations for Vineyarder shufflers were "divided into two seasons . . . summer housing, typically lasting between four and five months, and winter housing for the remainder of the year" (Tumin 2012:1). Rents rose, for example from \$1,500 a month (from fall to spring) to \$3,150 a week (Tumin 2012:1). Some Vineyarders camped in tents (Gay 1998; Carpenito 1998:196; Hull and Elvin 2014:6; Martha's Vineyard Commission 2006:2), lived on their boats (Tumin 2012:6), slept in their automobiles, squatted or borrowed living space (Ferdinand 2000:C-8; Kelley 1998:2) each summer. Some Vineyard home owners "shuffled" off-Island each summer so they could pocket the significant difference for the rent they charged and that rent which they were charged on the mainland (Tumin 2012:6; Gay 1998). Some homeowners stayed on Martha's Vineyard and rented to people who shared their living quarters. Those renters whose could not stay in their dwellings year-round maintained a constant vigilance in search of stable rents. Many experienced anxiety over the potential

for not finding housing in Martha's Vineyard's scarce housing market (Tumin 2012:1). Shuffling likely became more difficult as one's family grew larger or as one aged.

Martha's Vineyard's reputation as a playground for the rich and famous was valid if one recognizes that such rich and famous made up a small percentage of Martha's Vineyard's population. This small population, as stated in the introduction, tended to avoid conspicuously displaying their wealth and their fame. Famous people could enjoy freedoms that they may not have been able to enjoy on the mainland. Vineyarders tend not to hound or request autographs from the famous. Wealthy Vineyarders might have displayed their wealth in ways that were recognizable only by those who shared their socioeconomic status. Nonetheless, a cultural longhand perspective enables one to see that huge income disparities promoted a sense of relative poverty on Martha's Vineyard. Relative poverty is the sense that one is impoverished because others in one's society possess more wealth or status accoutrements. The amount of wealth that produces a sense of one's impoverishment rises as the standard of living improves (Fisher 1997).

Relative poverty was not new to Martha's Vineyard. In 1930:

the New York Yacht Club arrived in Edgartown Harbor with more than one hundred sail and power boats in its fleet. One of these boats, the *Enterprise*, was worth \$630,000. By contrast, the total operating budget for Edgartown that year was \$95,570 (Boeschstein 1999:111).

As today, during summer in the 1970s, a year-round Vineyarder recognized:

the contrast between his possessions and those of the visitor to his island. The island, during most of the year a repository of old automobiles called “Vineyard cars” because no one dares to drive them off the island, is suddenly flooded with the latest models of . . . vehicles. He sees yachts anchored in the harbors whose upkeep takes more than he earns all year, and at the end of the summer he searches for and finds in the town dumps household objects discarded by summer visitors that . . . grace his own house (Mazer 1976:55).

As Tony Lombardi explained, the “Island economy . . . forces families to work two or three jobs—we all work a lot” (Wilson 2011:3-A).

Another sacrifice Vineyarders made was limitations in the kinds of health care specialists one could access on Martha’s Vineyard. Some health care professionals claimed that people with certain health conditions would be unwise to live in a place that is isolated from tertiary medical centers and physician specialists. Also, Vineyarders often could not choose among competing health care providers (unless they went to the mainland for health care). There was only one hospital on Martha’s Vineyard. Also, it was difficult to change physicians because many physicians were not taking new patients, especially one who already had a physician. A study participant noted a limitation in the Island’s visiting nurse organizations. After her relative relocated to the mainland, she found that this relative was able to receive significantly more visiting nurse visits. She claimed that the relatively sparse number of visits had been a result of shortages of nursing and therapy staff on the Island. While Vineyarders endured such limitations, they gained health care professionals who knew them (perhaps also prior to the health care encounter) and had more time to familiarize themselves with their patients’ medical histories.

Allie Horowitz characterized year-round Vineyarders who have endured such limitations and forewent such accoutrements to live on Martha's Vineyard. She stated, "If you love a place and you feel committed to it and really appreciate the beauty it has and the energy it feeds into your life you compromise, you do what you need to do to make it work" (Tumin 2012:1). Vineyarders' love for Martha's Vineyard led them to rally in their efforts to impede threats to Martha's Vineyard communities. Such threats and the actions that Vineyarders took to mitigate them are discussed and described below.

Threats to Martha's Vineyard Communities

A community is able to exist because it is opposed to one or more other communities (Cohen 1985:58; Donnan and Wilson 1999:24). As Cohen (1985:109-110) argued, a sense of community (and of community distinctiveness) can become more pronounced if community members view outsiders as posing a threat to their community values. A community member's "sense of self . . . is always tenuous when the physical and structural boundaries which previously divided the community from the rest of the world are increasingly blurred" (Cohen 1985:109). On Martha's Vineyard, outsiders (mainlanders) who vacation and who purchase homes on the Island drove up the costs of summer rentals and home ownership. This has threatened the viability of Vineyarders staying on the Island.

Several study participants claimed that Martha's Vineyard's high cost of living (especially housing costs) was the largest threat to Martha's Vineyard communities because it forces Vineyarders to be pushed off-Island. For some:

All it takes is a rainy summer or an extra cold winter and a dual income family can find they don't have enough to pay the fuel bill, rent and buy groceries . . . Every year, some people find that Island economics are taking too much of a toll out of their quality of life and they leave the Island (Martha's Vineyard Donors Collaborative 2011).

Vineyarders claimed that too many emigrating Vineyarders could have led (or had led) to community disintegration. Emigrating Vineyarders take away their skills, their knowledge about Martha's Vineyard (Peters 2000:A-7; Hough 2000:4; Kelley 1998:2), and their Vineyard community values. Among those who had emigrated were young adults who grew up on Martha's Vineyard (Allen 2005:226; *Vineyard Gazette* 2009a:8) and other stewards of Martha's Vineyard that included nurses, physical therapists, teachers, farmers, fishers, tradespeople, bank tellers, cashiers, custodians, town government and other nonprofit organization employees, artists, plumbers, electricians, and police officers (de Veer 2004:20; Kildegaard 2004:9; *Vineyard Gazette* 2009a:8; Peters 2000:A-1, A-7; Hough 2000:4, 5; Ferdinand 2000:C-8).

The lack of affordable housing exacerbated labor shortages (Peters 2000:A-1, A-7). This made it difficult, as some Vineyarders claimed, for Vineyard business owners to stay open during the entire summer which, in turn, led them to emigrate (Peters 2000:A-7). Summer was the only time of year when most Vineyard businesses flourished. High housing costs pushed some business owners off-Island to some place where there was not a shortage of potential employees and where they were not forced to close during part of the most profitable time of the year (Peters 2000:A-7; Ferdinand 2000:C-8). Difficulties finding employees led to the closing of a unit at Windemere after Windemere experienced "chronic staff shortages" (Wells 2000b:1).

Other factors led to forced emigration. Some health care professionals lamented that living on Martha's Vineyard could be problematic given the scarcity of some kinds of positions and health care organizations in which to apply for jobs. The firing of health care professionals could prevent them from staying on Martha's Vineyard. While as discussed above, Vineyarders tended to be less competitive than mainlanders. However, intense competition could ensue among those who held a kind of occupational position in which only a few existed on the relatively isolated Island. High-ranking HCAs tended to fervently protect their positions, as these positions were scarce on Martha's Vineyard. If an HCA were to lose that position, chances were good that HCA would have had to either relocate to the mainland for an equivalent position or stay on Martha's Vineyard with little chance of finding such a position.

According to Vineyarders, Martha's Vineyard's high cost of living and other conditions discussed later led many physicians to stay on Martha's Vineyard only for a short time. This prevented them from becoming longtime Vineyard physicians (such as Lew quoted above) who followed their patients over time. Hence, they could develop a sense of patient histories only by reading their charts.

Martha's Vineyard newspapers gave much attention to that which Vineyarders often claimed. Martha's Vineyard communities and quality of life were at risk because too many love the Island's beautiful and easily traversed natural terrain, views, relatively clean environment, rural landscapes, ocean surroundings, small, diverse, local communities, and its cultural diversity. Year-round Vineyarders often welcomed Vineyard visitors and summer home owners. However, many if not most, dreaded the

crowding, high prices, housing scarcities and other social ills the surge of population brought each year. As Judy Crawford put it, “at some point we’re going to hit that critical mass where we start losing our whole identity – we start losing what it is that is Vineyard” (Kildegaard 2004:9). Like other Vineyarders, Crawford used the imprecisely defined term “Vineyard” as an adjective. While such Vineyarders advocated for the maintenance of that which is “Vineyard,” it is likely they held different definition of characteristics that define “Vineyard.”

Vineyarders often viewed increases in newcomer populations, their penetrations into Martha’s Vineyard social boundaries and the values they propagated as impediments to community intimacy, traditional community values, and culture (Gay 1998). Cohen (1985:98) defined “culture” as “the community as experienced by its members.” A rapid influx of newcomers diminished Vineyarders’ sense of knowing everyone on Martha’s Vineyard or in one’s town. Cultural “encapsulation” (Newby 1980:259) is that which occurs when large influxes of newcomers who are not assimilated into traditional culture exclude those who are assimilated. A school teacher provided an example of such encapsulation when she claimed that her native Martha’s Vineyard students could no longer gain a one-upmanship by claiming they are Vineyard natives. A Vineyarder captured such encapsulation when he stated that at an earlier time he remembered when fishermen from families such as:

the . . . Mayhews and Larsens, Pooles and Vanderhoops – inhabited a different world than most of us summer folk, but I don’t recall that anyone ever noticed. The men who worked on the water were not only respected by the summer crowd of bankers and lawyers, they were revered.

Getting to know such men was probably easier in those uncrowded days when, even if you were a summer person, it was assumed that you shared a love of the place or you would not be here. In those days, the island was an inclusive place (Low 2001:23).

Such encapsulation can be exemplified by “Washashores” who “disparage the culture of the place” (Pace 2005:74):

There is probably no simpler illustration of the dominant news themes of Martha’s Vineyard, 2007, than that of the friendly Rhode Island red rooster. . . . Chickie, who Ms. Seidman hatched from an egg almost five years ago when she was 11 and then kept as a pet, had won four firsts at the annual Martha’s Vineyard Agricultural Society Livestock Show and Fair

Then in late January, the Tisbury zoning board of appeals told her to get rid of him. A neighbor — a seasonal resident — had hired an attorney to complain about the noise Chickie made. . . . The case is still under appeal, expected to go back to court sometime in 2008. In the meantime, the rooster has won a fifth title at the fair. . . . Chickie . . . was caught up in a type of dispute that had grown more common as the increasing creep of suburban values collide with the traditional rural way of life (Seccombe 2007c:1).

Vineyarders pointed to technological innovations that provided opportunities for people to dilute Martha’s Vineyard’s community ideals. Such innovations shortened ecological distances. “Ecological distances” are physical distances as measured by time and energy to traverse from one point to another (Park 1926:11). Distinctiveness can come under assault when faster modes of transportation and more efficient modes of communication weaken structural community boundaries (Peace 2001:5; Cohen 1985:44). Had ferry services not been available, few would visit Martha’s Vineyard. Ferries to Martha’s Vineyard (shown in the introduction) have been run from increasingly more places such as the New York City and Highlands, New Jersey ferries that ran only during peak tourist visitor days (Seastreak Ferry 2017).

New forms of communication such as television and more recently, the internet eroded Martha's Vineyard's isolation. Vineyarders pointed to widely publicized events that "put Martha's Vineyard on the map." These events included Ted Kennedy's accident in the late 1960s when he drove off a small bridge into Pocha Pond (on Chappaquiddick) and his passenger, Mary Jo Kopechne died (Meras 1970:4); the filming of the movie "Jaws," in 1974 (Ashe 2013b:6; Taylor 2011), and former US president Bill J. Clinton's visits to the Island in 1990 (Seccombe 2009b:1-B).

Some Vineyarders claimed they were influenced by mainstream, corporate media brought to the Island over the airwaves or water. Advertisements on mainland television stations and in mainland newspapers had enticed many Vineyarders to go shopping on the mainland. Some Vineyarders who did not have plans to travel to the mainland claimed they were frustrated when they saw advertisements for goods not available on the Vineyard or advertised at significantly lowered mainland costs. The ease of ordering products online put both mainland and Martha's Vineyard store front retailers under threat. Some Vineyarders claimed that the internet was significant starting in the 1990s when wealthy "dot.com" people began relocating to Martha's Vineyard. The internet enabled them to submit their work online to their mainland employers. Some study participants argued that this led to relative poverty becoming more pronounced on Martha's Vineyard. A school teacher claimed that the deepening relative poverty led her to no longer ask the students what they did during their vacations. Highlights of their vacations ranged from going to a local Martha's Vineyard restaurant for pizza and skiing

in the Swiss Alps. While change marched forward on the Vineyard, Vineyarders continued to advocate for those traditions they held dear.

Vineyarders' "references to the past – timelessness masquerading as history" (Cohen 1985:103) were apt symbols that portrayed a continuity of past and present. Such a portrayal enabled people to reassert the community's cultural integrity—especially if change threatened to subvert the community (Cohen 1985:103). Vineyarders often expressed a desire for a return of those ideal Martha's Vineyard communities they recalled while they were young or when they first discovered Martha's Vineyard. Many Vineyarders promoted a return of real, imagined or invented attributes of yore and desired the same for their children. It was not difficult to find examples in the Martha's Vineyard media. Jeremy Mayhew hoped his children could enjoy up-Island, small-town, rural life that included being allowed to enter the Chilmark Store barefoot and not worrying about automobile thefts if they were to leave their keys in their automobiles (Fein 2006:1). Jim Athearn contrasted his bucolic, Vineyard childhood with Martha's Vineyard today:

All my adult life I've been disturbed by the pace of development . . . It grieves me . . . We once had woods with real depth, where you could hike and camp . . . and fields with woods in back of them instead of a row of trophy houses. Now, people who don't know and don't care come in and plop a house down and then go back to North Carolina, but you've got to live with it. That has left me unhappy for a good part of every day for the last 30 years—this constant nagging about what you're going to lose next. You drive down the road and see a great gash through the woods, or a hilltop with big piles of sand on it . . . another hilltop gone (Kemper n.d.).

Another lamented the loss of the Martha's Vineyard community she remembered:

One of the best things about living two blocks from downtown Edgartown is being able to easily walk to the hardware store . . . The walk clears my mind, plus, there are . . . opportunities for socializing along the way . . . Edgartown Hardware is one of the original stores on Main Street - well, as far back as I go, anyway - and the last of the vital services that remains; the last of the “real” stores, a store where you’ll find something useful, something necessary for living, and one of the few stores that is open during the winter, Edgartown being a virtual ghost town from December to March . . . The relocation of Edgartown Hardware to the outskirts of town is the completion of the exodus that was begun in 1960 when the A&P moved . . . to . . . Upper Main Street (Piazza 2010).

Such threats led Vineyarders to form collectivities and advocate for their communities.

Vineyarders’ Efforts to Protect Martha’s Vineyard’s Community Life

Many Vineyarders took part in Martha’s Vineyard town, Dukes County and non-governmental nonprofit organizations where they could exert their influence and helped to prevent the demise of Martha’s Vineyard communities. Vineyarders helped particular individuals who underwent a tragedy or who could not access housing or health care. Some helped groups of individuals on the basis of particular criteria that enabled them to qualify for receiving such help. Those who helped an individual may have simultaneously promoted a collective. For example, if one helps another to pay for health care, the health care organization also benefits. Also, if one supports a collective, each member of that collective may benefit. One could benefit from another’s self-motivation. For example, a physician who practices medicine solely for the money may help patients. Altruists may benefit from the personal satisfaction they gain from their altruism.

Much archival data and many Vineyarders described the collectivities they formed and joined to promote access for some individuals or to all Vineyarders who chose to gain access. Such collectivities protected, promoted and maintained Martha’s Vineyard

communities, cultures and social spaces. They implemented both egoistic utilitarian and collectivistic utilitarian solutions. These Vineyard advocates were united by both mechanical solidarity and organic solidarity. Emile Durkheim contended that divisions of labor were maintained through either one or both of two kinds of solidarity: mechanical solidarity or organic solidarity (Cosser 1997:xvi; Durkheim 1997:60-61, 83-85).

Vineyarders who volunteered in Martha's Vineyard nonprofit organizations exhibited a shared belief in a common good. Vineyarders who joined and supported such an organization were united by that specific cause which members of their organizations advocated. They were also united by organic solidarity while they pooled their particular talents on behalf of the organizations and the people these organizations served.

Advocates for affordable housing had made efforts (on a case by case basis) to prevent Vineyarders from being forced to relocate from Martha's Vineyard because of housing scarcities. The Wampanoag Tribe's Housing Department helped members of the Wampanoag Tribe to obtain stable housing. This department was responsible for administration of a thirty-unit housing development on the 475-acre tribal trust lands in Aquinnah¹⁵ (Manning 2010). Other nonprofit affordable housing organizations included Martha's Vineyard housing assistance programs and Habitat for Humanity. The Dukes County Regional Housing authority was legislated in 1986 to help low and moderate income people, the elderly and the disabled to find affordable housing (League of Women Voters 1988:33). The Dukes County Housing Authority and the MVC affordable housing program required real estate contractors to convey or sell ten percent of a subdivision's lots to the Housing Authority (League of Women Voters 1988:33). Then the Housing

Authority sold them at 25 to 50 percent of their market values (League of Women Voters 1988:33). Between 2007 and 2011, the Martha's Vineyard Housing Trust held lotteries that awarded new homes to 42 families at prices based on their incomes (Myrick 2011b:9). Also, inhabitants of approximately 90 apartments received rent subsidies in 2011 (Myrick 2011b:9).

These programs enabled few fortunate Vineyarders to receive housing rental or mortgage subsidies (Cabot 2005b:16). In 2012, 204 Martha's Vineyard households were on the waiting list for rental assistance. This number had dropped compared with a few years beforehand when 300 were on the waiting list (Tumin 2012:1). Perhaps this drop could have been explained by Vineyarders on the waiting list having relocated to the mainland, having received help from another source, or no longer having qualified for rental assistance programs.

Vineyarders' commitments toward nonprofit land and habitat conservation organizations demonstrated that they valued Martha's Vineyard's land and habitats. Majorities of Vineyard voters demonstrated their strong commitments when they voted in favor of establishing and maintaining conservation efforts, including those that were funded through taxes and mandatory fees. Town taxes paid for MVC services. The Martha's Vineyard Land Bank (MVLB) charged a two percent surcharge to most who sold Martha's Vineyard real estate to acquire its revenue (Martha's Vineyard Land Bank Commission 2013:9; Wells 2004:9). Mid-1980s Vineyarders established the MVC and the MVLB in response to uncontrolled development on Martha's Vineyard

(Boeschstein 1999:111; Martha's Vineyard Land Bank n.d.). Such land use organizations purchased land and enabled all Vineyarders who chose to access it.

A majority of voters in all six Island towns had also approved acquiring Community Preservation Act (CPA) funds. These funds were obtained through Massachusetts property transfer fees (\$20 each in 2007) and residents of each town paying a surcharge (up to three percent) on their property tax bills (on which the Commonwealth of Massachusetts provided matching funds) (*Vineyard Gazette* 2007:8). Town voters decided for which projects CPA money would be used by majority vote. Such funds were used to promote farming, open space, historic areas, recreational activities and affordable housing availability (Hickey 2012:7, 9; Seccombe 2007a:1, 10).

The protected districts on Martha's Vineyard shown below in Table 12 pointed toward Martha's Vineyard attributes that Vineyarders viewed as important. The nonprofit organizations that protected these districts did not necessarily strive to eliminate all development but rather strived to prevent development that would have been detrimental to the district's existing character.

Individuals within a special overlay district (Table 12) are required to abide by zoning regulations along with additional regulations particular to that kind of district (Town of Chilmark 2017:11-1; Town of Tisbury 2017:107). Special overlay districts not depicted in Table 12 protect particular places. Those located down-Island include Cape Pogue and Katama Airfield and Conservation area in Edgartown (Town of Edgartown 2011:57, 61), Southern Woodlands, and Wesleyan Grove (the Methodist Camp Meeting "Campgrounds") in Oak Bluffs (Town of Oak Bluffs 2016:79-80; Martha's Vineyard

Commission 2015), and William Street in Vineyard Haven (Martha's Vineyard Commission 2015). Those located up-Island include Squibnocket Pond; Menemsha, Nashaquitsa and Stonewall Ponds; and the Meetinghouse Road/Tiasquam River in Chilmark (Town of Chilmark 2017:3-3, 11-7, 11-8, 14-1), the Moshup Trail, Gay Head cliffs, and as stated in Table 12, the town of Aquinnah (Town of Aquinnah 2016:38, 40-41, 43). Some districts, for example, the North Shore District (Tisbury, West Tisbury and Aquinnah) (Town of Aquinnah 2016:56; Town of Tisbury 2017:135; Town of West Tisbury 2009:38) span across more than one town.

It does not mean that a town lacked protections if a particular district was not listed. Each of the Vineyard towns had a conservation commission (Town of Aquinnah 2016:20-21, 25, 51; Town of Chilmark n.d.; Town of Edgartown 2011:47, 85; Town of Oak Bluffs 2016:77, 87, 90, 106; Town of Tisbury 2017:109, 120; Town of West Tisbury 2009:36-37, 39, 65, 69) that administered local town and Massachusetts state regulations to protect the town's wetlands, open spaces; water recharge areas; flood plains; and industries such as agriculture, fishing, and forestry (Town of Chilmark n.d.). They were required to follow federal regulations mandated by the US Department of Agriculture and the Army Corps of Engineers and to oversee conservation restricted properties (Town of Chilmark n.d.). Vineyarders protected historical and cultural places, marine environments, ponds, agricultural land, open spaces, and rural characters (Town of Aquinnah 2016:55; Town of Chilmark 2017:2-5; Town of Edgartown 2011:78, 85; Town of Oak Bluffs 2016:44, 47, 72, 85-87, 108; Town of Tisbury 2017:93; Town of West Tisbury 2009:1, 21, 24, 29, 30, 66).

Table 12. Districts listed in town zoning bylaws, their locations, and their purposes								
District	Town located						Purposes such as to protect, maintain, or promote:	
	E	OB	T	WT	Ch	Aq		
Business	■	■	■	■			Public health; pedestrian use; small-town characteristics; mitigate traffic congestion	
Waterfront/marine commercial			■			■	Marine uses, year-round businesses, water quality, public access	
Residential	■	■	■	■			Character of neighborhood	
Residential-rural/ag				■	■	■	Rural character	
Health care		■					Vineyarders' well-being	
Special overlay	Coastal	■	■	■	■	■	Water quality; marsh, beach grass, economic development; scenic views	
	Groundwater		■	■			Drinking water	
	Harbor		■				Economic, residential, environmental	
	Marine/chan			■			Geographical and man-made features	
	Ponds	■					Character, resources, wildlife, shellfish, scenic vistas	
	Roads	■	■	■	■	■	Safety; walks; horseback, scenery, diversity	
	Special places	■	■		■	■	Resources, ponds, wildlife habitats, and visual character; green belt buffers	
	Special ways	■		■	■		■	Old paths; non-motorized transport
	Streams, wetlands					■		Land, water within 100' of streams, wetlands, and ponds
	Aquinnah						■	Town's rural and visual character, culture
North shore			■	■		■	Beauty, littoral drift, flora, fauna	
Conservation					■		Adequate or no development	
Copeland Plan		■					Victorian style architecture	
Historic	■	■	■	■		■	Historic characteristics, architecture	
Floodplain	■	■	■	■		■	Avoidance of flood/storm damage	
Planned development	■						Complementary land uses; open space	
Surface water	■						Clean water, marine flora/fauna; safety	

Ag=Agricultural; Aq=Aquinnah; Ch=Chilmark; chan=channels; E=Edgartown; OB=Oak Bluffs; T=Tisbury; WT=West Tisbury

Sources: Martha's Vineyard Commission 2015; Town of Aquinnah 2016:5, 7, 34, 35, 43, 54, 56; Town of Chilmark 2017:3-1, 3-2, 3-3, 11-2, 11-3, 11-5, 11-6; Town of Edgartown 2011:7, 16, 18, 19, 25, 27, 49, 51-52, 56, 65, 74, 81, 84; Town of Oak Bluffs 2016:10, 11, 13, 55, 57-58, 68, 70-72, 75, 77; Town of Tisbury 2017:20, 24, 29-30, 43, 44, 46, 49, 71, 107, 110, 113-114, 119, 120, 124-125, 130, 135; Town of West Tisbury 2009:1, 3, 23, 25-26, 29, 35, 38.

Unlike the Arts District (Schultz 2004:60-61), the districts in Table 12 were protected legally. The Arts District was not designated by the town. Rather, those who owned galleries and supported the arts created an arts district to promote their galleries, boutiques, and jewelry studios located in a small section of Oak Bluffs (Schultz 2004:60-61; Robards 2012).

Vineyarders promoted their local business communities while they advocated for people to shop locally and to purchase items made or grown on Martha's Vineyard. Such organizations included the Island Grown Initiative and the Martha's Vineyard Chamber of Commerce. Vineyarders helped local business entrepreneurs to overcome obstacles to setting up businesses. It was likely Martha's Vineyard's small size, expensive land and geographical isolation helped also to prevent large agro-businesses from locating on Martha's Vineyard. Like mainland town officials (Jackson-Smith 2003:314-315), Martha's Vineyard town officials created conservation easements, preferential tax policies and economic development programs to promote maintaining land for agricultural uses to mitigate somewhat the high land costs that made it difficult to open farming businesses on Martha's Vineyard.

Martha's Vineyard's fishing industry was threatened as a result of high costs to operate such a business and diminishing returns. Chilmark officials made significant efforts to protect and promote Menemsha's fishing industry and its character as a fishing village. Town officials charged only nominal or no fees for docking a fishing boat in Menemsha and low rents¹⁶ to Menemsha fishing business owners (Lovewell 2006b:1;

Rappaport 2007:1, 5). Shellfish constables promoted shellfish propagation, prevented and remedied shellfish habitat pollution, oversaw the predation program, and enforced state and town shellfish regulations. Chilmark fishers formed the Menemsha Fisheries Development Fund in 2007 for projects that promoted Martha's Vineyard's fishing industry and Menemsha's fishing village projects.

These efforts had done little to quell the effects of federal fishing management policies devised since the 1960s and competition from large foreign fishing fleets (Doeringer, Moss, and Terkla 1986:15, 25, 27-28). By the mid-1970s, a declining stock was coupled with Americans' increased demand for fish in the US (Doeringer, Moss, and Terkla 1986:25; Brannen 2010:7). Rather than protecting fish stocks (Nadel-Klein 2003:134), government officials had hindered small-business fishing. As Vineyard fisherman Eric Cottle noted, federal government legislators promoted the "people with no sense of the natural cycles of the sea to invest in huge new fishing boats . . . to rake up the stocks" (Lovewell 1999:4B). Such regulations provided, as Vineyard fisherman Jonathan Mayhew had put it, "death by a thousand cuts . . . to the small and medium sized dragger" (Lovewell 2006a:1). Such regulations benefitted those who over-fished, while they provided only paltry allocations to small fishers (Playfair 2003:11; *Vineyard Gazette* 2003b:10; Lovewell 2007:12; Brannen 2011:1). Vineyard fisherman Roger Fleming claimed that such regulators were written to "control the fishermen instead of trying to control the numbers of fish that are removed" (Lovewell 2006a:4). Martha's Vineyard town home rule did not extend to the sea.

Martha's Vineyard's ocean boundary protected Martha's Vineyard from corporate penetration. Arguably, from a corporate official's perspective, Martha's Vineyard could be viewed as an encapsulated¹⁷ community that had erected boundaries to keep all but a few corporate chains from locating there. Vineyard writers claimed that the late-1970s proposal to allow a McDonald's® to penetrate its "virgin" borders (Hough 1980:153-168; Gay 1998; Hart 2005:6) was antithetical to Vineyard ideals. The *Vineyard Gazette* editor stated, "this project will signal the beginning of the end of Vineyard Haven as a superior town in which to live" (Hough 1980:156).

Preventing corporate chains from locating on Martha's Vineyard helped to maintain friendly business relations. Corporations tended to hold uniform policies for their many employees that resided over huge geographic areas. Policies formulated by Martha's Vineyard's small businesses tended to impact their few employees that resided in the local area. Vineyard merchants and customers often trusted others. For example, one claimed she encountered a friend with whom she continued to converse while leaving a store. On her way home, she was surprised to find she was carrying a half gallon of ice cream. Upon returning, the shop keeper addressed her by first name and said that he did not stop her when he noticed her leaving the store with the ice cream because he was confident that she would return to pay for it.

Though rarely, if ever conducive to lasting change, Vineyarders rallied around clinicians after they learned that their employers had maltreated them. This was significant because if one could not eke an existence on Martha's Vineyard or could not find viable employment, one could be forced to relocate to the mainland. Vineyarders

supported Martha's Vineyard Community Services's (MVCS) mental health counselors who unionized in 2002 in response to disputes over low wages, high personnel turnover and disrespectful managers (Locke 2002:1, 12; Locke 2003b:7). In 2003, Carly Simon, a Martha's Vineyard second home owner and a nationally-known popular musician stated that she empathized with the MVCS personnel who were paid such low wages. That year she and children-book author, Norman Bridwell provided each non-administrative MVCS employee a Christmas bonus of approximately \$100 out of their pockets. They arrived at that amount after they had tried to convince MVCS administrators to give 30 percent of that which they raised (\$50,000) at the annual MVCS Possible Dreams auction (Locke 2003a:1; Lovewell 2003:1). It appeared that MVCS continued to pay its nurses and mental health counselors low wages. Several study participants voiced their disapproval of MVCS employees' working conditions and pay.

A small number of study participants claimed they would not donate to Hospice of Martha's Vineyard (Hospice) because in 2005, a highly respected Hospice director was fired without due process¹⁸ (Fitzgibbon 2005:29). Vineyarders both within (Fitzgibbon 2005:29; Colon 2005:24; Hay, Fitzgibbon, and Friedman 2005:16) and outside (Burt 2005:19; Case 2005:24; Kennedy 2005:15; Murphy 2005:18) of Hospice wrote letters on behalf of the former director or to express their disappointment that valued Hospice employees quit in response to this firing. Two Hospice nurses and a psychologist resigned from Hospice after the director was fired (Sigelman 2005a:8; Fitzgibbon 2005:29; Colon 2005:24). A Vineyarder stated publicly that these clinicians were "kind, thoughtful, and trustworthy . . . They have lived and practiced in this community for

many years and are respected contributors to Hospice patients and their families” (Colon 2005:24).

Martha’s Vineyard Hospital’s public relations had experienced periods of propitiousness and deterioration at least since the early–1980s (White 1981a:1; White 1981b:1; White 1981c:1). Newspaper editors had made significant efforts to inform the public about the incompetent management of MVH’s financial affairs, its contentious HCA-employee relations, and its HCAs’ attempts to deceive the public. The climate at MVH led the *Martha’s Vineyard Times* editor (2002:16) to assert that MVH had been “the perennial frontrunner . . . in the race for the title of most disheveled Vineyard institution.” Prior to that, he had claimed its “commitment to the community has always been in doubt” (*Martha’s Vineyard Times* 2001:18) and that “to be the hospital Martha’s Vineyard needs, this hospital must accept responsibility for Island health care, which it does not now do” (*Martha’s Vineyard Times* 2000:14).

Many study participants recalled the mid–1990s newspaper reports about MVH’s poor management that had culminated when MVH declared bankruptcy. Between 1994 and 1996, during which time an analysis showed that MVH had been bankrupt (Wells 1997a:1), MVH cash reserves were being “thoroughly depleted” (Wells 1997a:1). During this time, senior managers were handing themselves “fat bonuses and sweet severance deals that amounted to hundreds of thousands of dollars in wage and salary increases” (Wells 1997a:1). In 1996, the year both MVH and Windemere filed bankruptcy (Wells 1997a:1; Wells 1997c:1, 5), conflicts between HCTs and HCAs led MVH’s board of trustees to resign *en masse*. These trustees had learned that administrators spent MVH’s

restricted endowment funds on its day-to-day operations (Allen 2003; Wells 1997a:1, 9). Several study participants and other Vineyarders claimed that MVH's bankruptcy led MVH trustees to relinquish control of MVH to Partners Health Care (Partners) (discussed later).

The turmoil that ruled the day leading up to the bankruptcy continued until just after the turn of the millennium. A *Boston Globe* journalist claimed that MVH went through five chief executive officers (CEOs) between the mid-1990s and 2003 (Allen 2003). According to Vineyard newspapers, from 1994 to 2002, six individuals stood at MVH's helm (Gay 1996a:1; Wells 1996b:3; Wells 1996c:1; Wells 1996d:1, 12; Wells 1996e:1; Wells 1997d:1; Wells 1999c:1, 6; Wells 1999b:1-B; Kelley 1999:1-B, 6-B; Wells 2002a:1). According to MVH trustee William Graham, these upheavals frightened away potential donors, patients (Allen 2003; Gentry 1999:NE4), Vineyard physicians, and potential physician hires (Mayhew 2001:33).

In 1989 and 1990, "Bitter feuding" (Delbonis 1990:4) occurred between nurses and administrators after nurses were being laid off (Delbonis 1990:4). Martha's Vineyard Hospital's power struggles, instability and HCAs' unfair style of management (Bochow 2002:9, 10) led MVH nurses to enlighten the public about their poor working conditions. They distributed leaflets at the 2001 Martha's Vineyard and Nantucket high school football game (Wells 2001d:7) to inform the Martha's Vineyard public of their plights. Hospital administrators were trying to switch nurses from a voluntary to a mandatory system of staffing if patient censuses were low. Had this mandatory staffing plan been initiated, nurses could have been required to leave work and be put on-call for only one-

third their hourly wage (Wells 2001d:7; Wells 2001c:3). Also, MVH was arbitrarily firing employees and threatening them if they were to speak publicly about MVH working conditions (Bochow 2002:9-10).

By the turn of the millennium, health care professionals and other Vineyarders were blaming MVH administrators for driving competent and trusted physicians to the mainland (Koehler 2002:17; Lord 2002:A-1, A-5). One of several Vineyarders claimed that MVH administrators threatened MVH's existence by their incompetence and their overemphasis on business orientations. As one put it:

Where has the hospital board been hiding from its oversight responsibilities that allow the working conditions which seem to exist between our health care providers and management, conditions that have become intolerable for many of our most able. . . . Our health and the hospital's viability are at stake. The bottom line is not the only criterion to be factored in for a nonprofit health care institution (Orleans 2001:12).

Low salaries and wages and poor working conditions on Martha's Vineyard had led non-management MVH clinicians to bargain collectively through labor unions (*Vineyard Gazette* 1973:3-A; Breslauer 1979b:1; Breslauer 1979c:1). Employees unionized to resist "unresponsive systems and ham-handed management" (Stein 2001:12) and to collectively bargain for better wages and other benefits. "The very fact that there is a union is a testament to the problems of the past" (Stein 2001:12).

In spite of the bad press such as the above, both year-round and part-time Vineyarders of a wide range of demographic groups supported the Island's nonprofit health care organizations (and others) through their donations of time and money. In 2004, Dukes County's ratio of nonprofit organizations (12.3 per 1,000 residents) was the

highest in Massachusetts and was more than three times the state ratio of 3.8 (Werkema and Leiserson 2005:22-23). These nonprofit organizations were “at work sustaining those qualities of Vineyard life which we cherish most” (Kildegaard 2011:15).

Opportunities to donate money to and do volunteer work for nonprofit organizations enabled Vineyarders to gain personal satisfaction and to return something to their communities. Many study participants, especially wealthy ones, claimed that they donated money and did volunteer work for Martha’s Vineyard nonprofit organizations in their efforts to “give back” to their communities. Some expressed their appreciation for having been deemed (real or imagined) worthy of “the good life.”

Opportunities to support health care organizations enabled Vineyarders to add significance, meaning and enjoyment to their lives and to build their legacies. Some reasons Vineyarders claimed they donated to a health care organization were that it was their civic duty to do so, that it was practical because they lived on Martha’s Vineyard, they used Vineyard health care organizations, and health care organizations needed help from the community. Like those who chose to be politically active, health care organization trustees and committee members tended to believe that, unlike in mainland communities, their impacts were felt on the Island. Some wealthy donors may have been motivated by social pressure exerted by their peers. Conversely, one claimed he donated a large amount to MVH as “a club” to encourage other wealthy Vineyarders to donate. “Rich man’s graffiti” (Ollman 1989) likely motivated many wealthy donors. A wealthy Vineyard philanthropist defined “rich people’s graffiti” as large donor names displayed on plaques in, on, or outside nonprofit organization buildings. Such graffiti and one’s

name being listed in annual reports could be a strong motivator for demonstrating that one had “won” the contest for wealth (Smith 2000:84). One might have “graffitied” buildings, walls and annual reports to save face among one’s peers. One high-ranking Vineyard official claimed that the sole reason she donated to her health care organization was to be named in her organization’s annual report and thereby, to avoid embarrassment.

Vineyarders of a wide range of socioeconomic statuses donated to MVH because they believed that Martha’s Vineyard needed a hospital in general or a new hospital in particular. Vineyarders viewed a new, state-of-the-art hospital with an advanced level of care as necessary because Martha’s Vineyard was isolated from mainland health care providers. Some claimed that Vineyarders were lucky to have the level of health care technology it had for Martha’s Vineyard’s small population. Some donated to MVH because they believed a new building was necessary because the hospital that existed at that time had a leaky roof and mold issues. Also, its electrical system could not accommodate increasing complexity in medical machinery, data transfers, and electronic medical record keeping. A handful of Vineyarders expressed critical beliefs with claims such as that the care in the new building would not improve because the same people would be delivering the care, the poor coordination of care would not be resolved, and not all Vineyarders would be able to access health care there.

That many Vineyard clinicians also donated to their nonprofit organization employers suggests the importance of occupational communities on Martha’s Vineyard. J. Van Maanen and S. R. Barley (1984:287) note that an “occupational community” is a:

group of people who consider themselves to be engaged in the same sort of work, whose identity is drawn from the work, who share with one another a set of values, norms, and perspectives that apply to but extend beyond organizational matters, and whose social relationships meld work and pleasure (Mills, Drew, and Gassaway 2007:2).

Vineyarders viewed their occupational communities as significant. Among study participants who identified one or more social networks as their communities, the largest percentage (22.8 percent) identified their occupational communities (Table 13).

Social networks identified	Percent of residents	
	Year-round (n=92)	Seasonal (n=8)
Members of occupation or those at workplace (n=23)	22.8	25.0
Vineyarders (n=11)	9.8	25.0
People know (n=10)	10.9	0.0
Members of a particular institution (n=19)	18.5	25.0
Members of a particular demographic group (n=17)	18.5	0.0
Friends, family members (n=17)	16.3	25.0
Vineyarders who join an activity or a cause (n=3)	3.3	0.0

Simple requests for donations were powerful motivators. The power of the word is discussed further in Chapter 2. Like HCCs who donated to Martha's Vineyard nonprofit organizations, Martha's Vineyard physicians, nurses and CNAs claimed they donated to their employers because they were asked. Other reasons included belief in MVH, people depended on MVH for care, MVH provided well for a former employee and she wanted to give back to it, MVH was a favorite charity, and because they worked there during the time of the interview. An MVH employee claimed she felt good about Windemere taking donations out of her paycheck each week because Windemere employees took better care of her significant other than mainland nursing homes did.

Efforts to Promote Health Care Organizations Vineyarders Use

Vineyard newspapers portrayed efforts Vineyarders purportedly made to benefit others as double-edged or as purely self-motivated. Perhaps Vineyarders' sense of dependence on their health care organizations led them to forgive health care organizations for their exploits. Some MVH officials took advantage of Martha's Vineyard community generosity. Vineyarders showed support for MVH just after the turn of the millennium when a majority of voters in each town strongly suggested that they "sincerely wanted to help their community hospital" (*Vineyard Gazette* 2001:10). Dukes County administered an inter-municipal agreement in which all six towns allocated a total of \$495,000 toward MVH emergency room operating costs in fiscal year 2002 (Sigelman 2001a:5; Sigelman 2001b:1; Sigelman 2001c:1). Some Vineyarders expressed unfavorable sentiments toward such a town allocation because MVH lacked transparency. A newspaper editor, some Vineyard town selectmen and other Vineyarders argued that MVH should have received tax money, only if the hospital were more accountable to the community (Breslauer 1979a:1; *Vineyard Gazette* 1999:8; *Vineyard Gazette* 1998:12; Aberg 2000:1, 4; D'Ambrosio 1999a:3, 5; Boardman 1999:8; Crafts 1999:15; Potts 2000:9). Others lamented that this money would not lower costs for using MVH's emergency services. One stated, "our tax money was going to 'ensure' the continuing services of the emergency room, but we would still have to pay for those services if we actually used them" (Revere 2001:30). Another lamented that "the difficulty the hospital is facing . . . is they have plumb priced themselves out of business, and now they expect the public to pick up the tab" (Lopez 2001:20).

Newspaper editors helped to prevent high-ranking MVH and Dukes County officials from hiding that they changed two sets of terms in this inter-municipal agreement. Until reported in the local newspapers, only the county manager, a Tisbury county commissioner who was also chairman of the emergency medical services committee, the MVH Chief Executive Officer and the MVH Chief Financial Officer knew that the county manager was planning to allocate ten percent of this money to the county (Sigelman 2001a:1; Sigelman 2001d:1; Sigelman 2001b:6). The county manager claimed that the county would be using the \$49,500 fee to cover legal and audit fees and “hourly labor to take emergency room information produced by a computer at the hospital and enter it into the county computer to create a new database” (Wells 2001a:14). A Tisbury selectman (Tom Pachico) claimed, “I am no computer expert, but why don’t you just use a disk and save yourself \$30,000” (Wells 2001a:14). Additionally, an MVH trustee and former Edgartown selectman Ted Morgan claimed that MVH already provided and published those data (Wells 2001b:7). This inter-municipal agreement controversy coming to light did not prevent the one-year contract from being carried out. Then someone furtively amended the contract so that “This agreement shall be for a term of *three years* from the date hereof” (Sabatini 2001:1, emphasis added). The original contract had been signed sometime around May 1, 2000 (Sabatini 2001:12). The amended contract was “dated . . . March of 2001. The [amended] contract bears the signatures of selectmen from the six Island towns – two of whom . . . have since died” (Sabatini 2001:12, brackets added for clarity). After this secret amendment was discovered, a newspaper editor claimed that as a result of these innovative officials:

Neither the hospital nor the county commissioners has enlarged the Island community's sense of confidence in the ability of either institution to conduct itself openly, economically, and responsibly when charged with a public trust (*Martha's Vineyard Times* 2001:18).

The county did not receive a cut and the inter-municipal agreement was neither extended nor reinitiated after its first year (Sabatini 2002a:5).

By the time of my relocation to the field, newspaper accounts showed that which study participants buttressed. Martha's Vineyard Hospital had improved its relations with the community. Martha's Vineyard Hospital success at turning around its failed community relations occurred during a crowded 2002 forum. The rash of negative community sentiments that had characterized that and earlier forums dissipated instantaneously. This was clear when applause filled the auditorium after MVH officials claimed that MVH's Chief Financial Officer was being promoted to CEO and again when they announced that MVH was about to become a Planetree¹⁹ hospital. The Planetree model of health care was formed in response to typical health care experiences that could have led one to believe "that hospitals set out to design systems that . . . deliver the worst possible experience to sick people" (Frampton 2003:xxvii). While hospitals use state-of-the-art technology, "our delivery has been pathetic" (Frampton 2003:xxvi). Patients were suffering needlessly also because "Health care often takes the same insensitive approach to dealing with . . . its employees . . . nurses in particular are burning out" (Frampton 2003:xxvi-xxvii).

Cynical Vineyarders claimed that MVH's major incentive to join Planetree was in an effort to raise donor funds for the new hospital. Campaigns for donations toward

MVH's latest hospital building were so effective that MVH did not have to borrow money to build (Seccombe 2007b:1B). Their cynicism was buttressed. Soon after the building was completed, MVH quietly discontinued its status as a Planetree hospital. An MVH employee stated that the Planetree Model was discontinued because it was viewed as an unnecessary expense.²⁰

Martha's Vineyard Hospital's ownership was transferred to Partners not long before the new MVH building broke ground. The nonprofit Partners formed when Boston's two most expensive hospitals, Massachusetts General (MAG) and Brigham and Women's Hospitals²¹ (both nonprofit) merged. Partners was the Boston region's "most powerful hospital and physician network" (Weisman and Kowalczyk 2010). Partners included many Massachusetts north shore hospitals and other health care organizations, including some located on the mainland Massachusetts south shore. Martha's Vineyard's Hospital's critical access hospital (CAH) status²² and perhaps also its excellent summer patient case mix made it lucrative for Partners.

Those who provided positive statements about MVH's transfer to Partners far outweighed the number who expressed critical concerns. While factors such as small population (Hart 2005:6), Martha's Vineyard's isolation and its rules concerning land use produced barriers and difficulties for large corporations that tried to exploit Martha's Vineyard's land and people,²³ many Vineyarders claimed that the MVH transference of ownership to Partners was advantageous. Many Vineyarders welcomed Partners because they believed it would prevent MVH from facing bankruptcy again. It would provide MVH with financial backing. It would reduce MVH's operating costs. Partners held

more clout than MVH when they purchased equipment, supplies, and physician malpractice insurance. The transfer to Partners would enable MVH to use Partners's already existing electronic medical record keeping system rather than starting its own and would enable MVH to modernize. Like in other rural areas (Renouf 2005:181), several study participants and other Vineyarders claimed that the most technologically-advanced health care facilities tended to be best. While many Vineyarders complained about the high costs of health care, they often lauded high technological (that is, capital-intensive (Shi and Singh 2010:103-104, 118 citing Littell and Strongin 1996 and Cassell 1993)) modes of health care. Also, MVH patient transfers from MVH would be guaranteed a bed at MAG. Hence, MVH officials no longer needed to request permission from mainland hospitals until finding one that would accept a critically ill MVH patient.

Some study participants claimed it was unwise to shift control of MVH from Vineyarders to mainlanders. One expressed disbelief that such a transfer could have taken place without Vineyarders demanding further analysis of what it entailed. One voiced concern because Partners had disregarded a contractual agreement and pulled out of it after Partners found the profits stemming from the contract to be disappointing. At a public forum, critical sentiments included that MVH and Partners cultures could collide, Partners officials could disregard Vineyarders' commitments to local communities, MVH could lose its autonomy, and MVH physician-patient relations could become more impersonal (Seccombe 2006b:9).

A study participant claimed that MVH and Partners manipulated Vineyarders into the low purchase price²⁴ of \$5 million. Perhaps this study participant believed that MVH

and Partners officials sped up the transfer process to give little time for public input. Discussions between MVH and Partners about this purchase had started in summer 2006 (*Martha's Vineyard Times* 2006a:16). Trustees at MVH unanimously agreed in December 2006 to approve the deal. This was only seven weeks after Partners and MVH began negotiations (Seccombe 2006a:1). Concerns such as those a newspaper editor raised were discussed little if at all with the public while negotiations were taking place.

These were:

how will Partners extend its excellent clinical care to an affiliate such as the Vineyard hospital. . . . ? How will MVH and its parent decide what services will be delivered here, and what will not, and how will it all, plus Windemere . . . be financed? How will the decision-making on such questions be made?

The Island hospital's officials have promised to engage Vineyarders in a discussion of these and other questions (*Martha's Vineyard Times* 2006a:16).

Partners's ownership of MVH and Nantucket Cottage Hospital enabled Partners to increase its federal reimbursements significantly. Martha's Vineyard and Partners-owned Nantucket Hospitals were the only CAHs in Massachusetts.²⁵ This designation had improved federal reimbursements for MVH and Nantucket Hospital and thereby reduced federal reimbursements for other Massachusetts hospitals. Under Partners, one of these hospitals was required to discontinue its CAH status.²⁶ This was expected to produce for Partners an additional \$60 million to \$80 million annually in Medicare funds (Seccombe 2006b:1). For Massachusetts hospitals overall, this amount was expected to be \$250 million (Seccombe 2006a:1). A Vineyarder claimed that MVH practically gave away MVH's new hospital building because Partners paid only one tenth of the approximate \$50 million it cost to rebuild. Partners would have recuperated its \$5 million in one

month if it had gained the \$60 million (the lower estimate) expected after Nantucket Hospital gave up its CAH status (Seccombe 2006b:1; Wyland 2013). As the *Vineyard Gazette* editor (2006a:14) put it, “five million dollars as a one-time payment balanced against seventy million in one year alone? It seems obvious that someone could have struck a better deal for the Vineyard Hospital.” Meanwhile, a Partners executive claimed that this deal was not motivated by profiting (Seccombe 2006b:9). However, Partners’s actions prior to purchasing MVH suggested otherwise.

Partners officials demonstrated that their words were used merely as tools to forward their agendas. The head of MAG claimed that their merging to form Partners would have improved health care and driven down health care costs (Allen and Bombardieri 2008). Brigham and Women’s Hospital’s CEO claimed, “We recognize that we can maintain excellence in leadership only by reducing costs of services and attaining ever superior quality of care” (*Boston Globe* 2008). Meanwhile, Partners was using its clout to obtain higher reimbursement rates (Allen et al. 2008; Allen and Bombardieri 2008). Partners and Blue Cross/Blue Shield CEOs may have broken the law in 2000 with their “handshake deal” (Allen and Bombardieri 2008) that exerted pressure on Blue Cross/Blue Shield’s competitors. This deal was that in exchange for Blue Cross and Blue Shield’s provision of significantly increased reimbursement rates to Partners, Partners would require other insurers to pay these same high or higher rates to Partners²⁷ (Allen and Bombardieri 2008).

Massachusetts’s Attorney General argued that price increases and market clout were most significant in driving up Massachusetts’s health care costs (Coakley 2010:2;

Division of Health Care Finance and Policy 2010:3, 22, 25). In 2007, Partners owned 16 percent of hospital beds in Massachusetts and amassed 35 percent of Massachusetts hospital profits (Allen et al. 2008). In 2008, MAG and Brigham and Women's Hospital (of Partners) were found to be receiving between 15 and 60 percent more than some other Massachusetts hospitals for the same services (Allen et al. 2008). Partners physician groups received more than two times the amount from insurers for the same kinds of health care services in the same geographic areas (Coakley 2010:7, 8).

Partners promoted increasing health care costs also by eliminating competing hospitals and physician practices. John Chessare, a Partners competitor, argued that Partners was “using that not-for-profit status to make a profit and to build more capacity for things we don't need” (Allen et al. 2008), such as expansion across suburban Boston. Partners's expansion led to less expensive suburban hospitals being forced to close or to be absorbed by more expensive providers²⁸ (Allen and Bombardieri 2008; Division of Health Care Finance and Policy 2010:22, 26; Allen et al. 2008). Partners offered physicians higher salaries than smaller community hospitals paid them (Allen et al. 2008; Division of Health Care Finance and Policy 2010:26). This loss of physicians to Partners put pressure on small community hospitals while Partners physicians referred their patients to the more expensive Partners health care providers (Allen et al. 2008). By 2008, while Partners was launching a \$4 billion construction program that included adding several outpatient facilities and 180 or more new hospital beds, 24 hospitals in Massachusetts were losing money (Allen et al. 2008). Other Massachusetts hospitals had merged in their efforts to compete with Partners. The literature outlined the poor results

that occurred after Beth Israel Hospital and Deaconess Medical Center merged (see Weinberg 2003).

Perhaps MVH power brokers viewed Partners's clout that enabled it to command high payments as advantageous. Its CEO claimed that housing costs for MVH employees and other expenses were significant factors that led MVH to charge high rates (Seccombe 2009a:7). It cost MVH approximately \$400,000 in 2003 (Allen 2003) to provide housing to some new employees in an effort to recruit them (Seccombe 2009a:7). As stated in the introduction, Vineyarders' average wages in general, were estimated to be significantly lower than the Massachusetts average (Martha's Vineyard Donors Collaborative 2011). However, MVH's CEO claimed that according to the Medicare wage index, Martha's Vineyard, Cape Cod and Nantucket wages were 30 percent higher than the Massachusetts average (Seccombe 2009a:7).

Chapter Summary

This chapter argued that Vineyarders traded wealth and occupational prestige and much easier access to mainland health care organizations for Martha's Vineyard idealism and intimate community life. Each Vineyarder established his or her community boundaries on the basis of how one experienced one's community. This chapter argued that Vineyarders viewed the ocean surrounding Martha's Vineyard as a boundary that, though pervious, protected Martha's Vineyard communities, cultures and land from harsh manifestations of mainland incursions. However, several threats existed, as discussed above.

Chapter 2 argues that Martha's Vineyard health care services are not ideal. It describes some of the methods Vineyarders used to include and exclude people from health care services. It describes methods insurers used to promote health care for the healthiest populations while excluding the less healthy and ways in which insurers manipulated their policyholders to avoid using health care services.

Chapter 2. Vineyarders' Health Care Value Orientations

Maintaining homeostasis is essential to good medicine, healthy lifestyles, and thriving communities. Martha's Vineyard's residents' close proximity and easy access to places such as the Martha's Vineyard seashore, conservation land trails, lakes, ponds, lagoons and quaint New England towns provided a beautiful backdrop within which Vineyarders could gain sustenance, promote healthy lifestyles, and enjoy community life. For Donald W. Light (2000:62), an ideal health care system promotes social solidarity. Such an ideal health care system would ensue if both health care providers and HCCs were to be sustained by the communities in which they live and work. Only those who spend recklessly on nonessentials would be strapped by debt or would be impoverished. Significant question concerning any health care system is, "who does it serve?" and "does it serve the community, the individual or both the community and the individual?"

Utilitarian Values: Business Orientations Versus Health Care Orientations

This chapter's discussion focuses on mainland and Vineyard health care providers' values that have played a significant part in inclusiveness of HCCs within and exclusiveness of HCCs from health care communities. It discusses ways in which health care professionals and HCCs have adapted to scarcities in health care resources. This chapter argues that health care organization officials' actions could be viewed as existing along an altruistic collectivistic and exploitative egoistic utilitarian values continuum.

The placement of actions discussed below along such a continuum has been left to any reader who desires. Vineyarders characterized utilitarian values in terms such as “health care oriented” or “business oriented.” Howard Stein (1998:82, 85-86) and Vineyarders exemplified “business values” by a system that promotes health care scarcities and concerns over who would pay for health care or over who would assume financial risks. Vineyarders may have framed such questions as, “do health care providers focus on profit so much that they deny people necessary health care services” and “do they have the community’s best interests at heart?” Stein exemplified “health care values” by care that is not “managed” (Stein 1998:81) and by the provision of optimum health care on behalf of the patient (and the community) without regard to the health care organization’s financial interests (Stein 1998:81, 85-86). The framing of this dissertation loosely within an altruistic–exploitive value continuum helps to explain health care organizations’ criteria for the inclusion and exclusion of patients from their organizations. First it explains inclusion of some health care providers who use certain modalities from mainstream health care. It argues, as the literature argues, that health care rationing came at a huge cost and wasted many health care and community resources.

Like altruistic and exploitive utilitarian values, health care orientations and business orientations are not mutually exclusive. Arguably, culpability for Vineyard physician shortages could lie with physicians or MVH who had maintained a shortage of physicians. Conversely, MVH officials who exhibited business orientations helped to promote improvements in Vineyarders’ access to health care. In an effort to gain physician referrals to MVH’s diagnostic and inpatient services, MVH helped to improve

the number of and the retention of Vineyard physicians. Many Vineyarders claimed that they had not been able to find a physician on Martha's Vineyard before these efforts were made. Martha's Vineyard Hospital adopted policies that enabled new Vineyard physicians to start health care practices and adapt to Martha's Vineyard's high cost of living. In 2001 it provided new Vineyard physicians startup loans. Then it provided salaries to physicians that MVH began hiring (starting in 2002) (Sabatini 2002b:1; *Vineyard Gazette* 2003a:5A). A guaranteed salary enabled new Vineyard physicians to thrive on Martha's Vineyard.

Since MVH improved the supply of Vineyard physicians, many claimed they could find a physician on-Island but still found it difficult to change physicians (unless one changed to a mainland physician). Vineyarders (including a high-ranking MVH administrator) buttressed the James T. Bennett and Thomas J. DiLorenzo (1994:60-61) and Carson W. Bays (1983:366) claim that nonprofit hospitals serve "most effectively to strengthen the restrictive character of the market for physicians' services and thereby serve the individual economic interests of the physicians" (Bays 1983:366). This is not entirely bad. As some Vineyarders recognized, maintaining a demand for MVH physicians held some benefits to HCCs (D'Ambrosio 1999c:10; Sabatini 2002b:8; Bamberger 1983:8). Vineyard physicians would have difficulty maintaining their skills if too many physicians were to practice medicine on Martha's Vineyard (Bamberger 1983:1, 8; study participants). Also, some Martha's Vineyard physician study participants claimed they took into account that which Thomas C. Crawford (2011:39) suggested, that

is, to take into account the level of demand for physician services before pursuing a medical position in a place of interest.

Sources of Alternative Health Care Rationing

A significant source of insurer health care rationing was that insurers rarely covered alternative medicine (defined in Chapter 3). Cultural diffusion brought a large diversity of healing practices (Ross 2012:1) that developed in contemporary politically and economically dominant (Ross 2012:3) biomedical (mainstream) and counter-dominant mainstream health care communities. Some study participants, especially those who used alternative health care, lamented that alternative medicine and mainstream medicine were not integrated. Many adherents to alternative medicine found their health insurance to be of little use because it rarely, if ever covered alternative medical services. Some claimed that they did not use alternative health care services because they could not afford to pay for services that insurers did not cover. Nonetheless, alternative health communities held a strong presence on Martha's Vineyard.

Scholarly works illustrated the trajectory of the development in the US of a culturally dominant mainstream health care system and another under the matrix of "alternative health care." Until the early-20th century, "regular," elite medicine was one of several dominant health care disciplines (Ross 2012:2-3; Warner and Tighe 2001:55, 125; Rosenberg 2001:112). Elite physicians stood apart because they used that day's fancy medical instruments, were licensed by their medical societies (Warner and Tighe 2001:55, 56) and used aggressive treatment methods (Ross 2012:3; Warner and Tighe

2001:56; Greenstone 2010:12-14; Swiderski 2008:xiv, 20, 39). Nineteenth century elite physicians who had studied scientific medicine in prestigious US and overseas universities and medical centers (Brown 1980:61, 72; Walker 1990:11-13) tried unsuccessfully to institutionalize their superiority (Warner and Tighe 2001:56) and to eliminate physicians they viewed as outsiders (Salmon and Berliner 1980:544; Starr 1982:91, 98). These elite physicians tried to dominate health care even in areas where they held little health care efficacy (Horne 1997:99) and although many could not afford elite physicians' fees and elite physicians were scarce in the sparsely-populated countryside (Brown 1980:61, 62, 63). The more regular physicians tried to reign supreme over their competitors, "the more they incurred hostility from other practitioners and from the public" (Warner and Tighe 2001:56).

Mainstream medicine did not achieve cultural dominance until the early 20th century after "robber baron" (Josephson 1962) philanthropists played a significant part in these two health care cultures emerging. Early-20th century elite physicians' achievement of cultural authority coincided with that day's empirical findings being "tempered by reason and rational inference" (King 1971:11). Not long before elite physicians were achieving cultural authority, the well-known 20th century pragmatist, William James had emphasized "the concrete, immediate, practical level of experience as the testing ground of our intellectual efforts" (Thayer 1972:433). He promoted exploitative utilitarians when he "described the meaning and truth of ideas as their 'cash value'" (Thayer 1972:433).

Their corporate wealth enabled these robber barons to build influential foundations that coincided with corporate expansion across the nation (Starr 1982:110). These foundations enabled mainstream medicine to assert their global dominance (Baer et al. 2012:243 citing Brown 1979; Brown 1980:125) while biomedical power brokers asserted their cultural authority (through persuasion) and constructed reality through their “definitions of fact and value” (Starr 1982:13). They imposed their metaphors that led us to interpret and explain “our” understandings and experiences on the basis of that which they conveyed through their metaphors (Lakoff and Johnson 1980:157; Starr 1982:4).

The Commission on Industrial Relations’s statement (1915:116-119), “the Rockefeller and Carnegie foundations’ policies are ‘colored, if not controlled, to conform to the policies of the country’s major corporations, which are themselves controlled by a ‘small number of wealthy and powerful financiers’” (Brown 1980:170) remains significant today. Andrew Carnegie and John D. Rockefeller used their philanthropic funds to set uniform health care standards and to institutionalize “undemocratic controls” (Brown 1980:169) in medical schools (Brown 1980:169; Drake 1994:29; Tippens, Oberg, and Bradley 2012:258-259). Through their foundations’ concerted efforts with the US government and the AMA (American Medical Association), Carnegie and Rockefeller commissioned Abraham Flexner’s study (Haley 2003:272; Brown 1980:10, 143-145, 152; Waitzkin 2000:42; Carter 1992:xxiv). Flexner published his report in 1910, two years after Henry Ford’s innovation of the standardized, assembly-line mass-production of factory goods. In responses to Flexner’s report these foundations allocated significant amounts to early–20th century medical education institutions (Brown 1980:11, 104, 173,

179). Flexner promoted emphases on biological sciences, scientific research, and use of technological tools (Tippens, Oberg, and Bradley 2012:258; Carter 1992:xxiv, xxviii), that is, capital-intensive biomedicine legitimated by science (Goldmann 1946:658; McKittrick 1949:999; Waitzkin 2000:42).

In the context of a push toward standardized health care, the AMA was able to promote a solidification of medical doctors' authority as professional scientists. While mainstream medical power brokers had not annihilated their competitors, they came out ahead. They had succeeded at co-opting or pushing undesired competitors to the margins of health care. Flexner's recommendations brought US medical science "from mediocrity to eminence, paving the way for world leadership in medicine in the years following World War I" (Drake 1994:29). Biomedical institutions in the US prevailed further after state medical licensing was being used as "a weapon repeatedly invoked against challengers to the . . . authority" (Horton et al. 2014:4 citing Starr 1982; Starr 1982:103) held by mainstream medicine power brokers. State governments backed the licensing of physicians and the ensuing restriction of physician supply. They backed capital-intensive medical interventions that drove up health care costs (Brown 1980:239-241).

Mainstream medicine power brokers' cultural authority had enabled them to widely disseminate the myth that unlike alternative modalities, mainstream medicine is based on rigorous science-driven research. However, differentiating the two systems by whether their treatments have been scientifically tested is not valid (Kopelman 2002:40-41). Some alternatives such as traditional Chinese medicine have been supported by scientific research (Ross 2012:4) and some alternative medical products have been tested

using higher standards than required in the US (Kopelman 2002:42). Jørgensen, Hilden, and Gotzsche (2006), Rising, Bacchetti, and Bero (2008), and Yank, Rennie, and Bero (2007:1204) noted that some mainstream medical research was conducted scientifically but the researchers showed bias when writing their results (Lo and Field 2009:105-108).

Rather than making medicine safer, government policies promoted weak medical research and the ensuing lacks in safety. Since the 1992 Prescription Drug User Fee Act (PDUFA) and the 2002 Medical Device User Fee and Modernization Act (MDUFMA) (HR 5651) were enacted, pharmaceutical corporations and medical device corporations have paid the US Food and Drug Administration (FDA) or hired private contractors to evaluate their products' safety and to inspect their plants (Geyman 2004:210, 111; Loudon 2005; *Public Citizen* 2002). Loudon (2005) argued that because a pharmaceutical industry wrote, performed, and paid for the VIGOR study, the cardiovascular risks were ignored. Physicians prescribed Vioxx to 20 million people though the VIGOR study (2000) showed that high doses increased risks for a myocardial infarction fourfold when taking Vioxx and Celebrex compared with taking Naproxin (Mechanic 2008:2 citing Brenson 2005; Loudon 2005). Food and Drug Administration power brokers ignored researchers' recommendations for further studies though they had found that Vioxx and Celebrex led to cardiovascular damage (Mechanic 2008:2-3 citing Mukherjee, Nissen, and Topol 2001 and Topol 2005). The FDA and Merck failed to inform physicians of these findings for four years (Mechanic 2008:2 citing Brenson 2005, Mukherjee, Nissen, and Topol 2001:954-959, and Topol 2005:366-368). The government and Martha's Vineyard's isolation failed to protect Vineyarders from such

malffeasance. Some Martha's Vineyard study participants claimed they underwent hospitalizations or suffered long term damage from prescription drugs including Vioxx.

Pharmaceutical payments to the FDA had more than doubled the FDA's Center for Drug Evaluation's budget (Geyman 2004:212 citing Pear 2002:A16; Loudon 2005). This conflict of interest improved chances that a product would be brought to market after undergoing FDA testing (Loudon 2005; Geyman 2004:211). The conflict of interest between private contractors that conducted pharmaceutical or medical device testing and the FDA stemmed from the contractor's desire for repeated business. Hence they had an incentive to provide favorable evaluations (*Public Citizen* 2002). Their weak methodologies included the use of too small a study sample; studies of long term interventions conducted over too short a time period; requirement, not of a more efficacious product but rather, of one that is not less efficacious than existing options; and a rigid adherence to drug comparisons with placebos even if that is a weak method for a particular study (Angell 2005:26-28, 240-242; Mahar 2006:78, 278, 280). Peter Rost (2006:151) attributed FDA scientists voting to return Vioxx, and keeping Celebrex and Bextra on the market to the fact that panel members held affiliations with the pharmaceutical industry.²⁹ Such pharmaceutical officials and government officials that protected them have significantly diminished the safety and efficacy of medicine.

Lacks in research standards persisted though the Institute of Medicine found that medication prescription, dispensation and ingestion errors led to 1.5 million Americans to suffer morbidity (sickness or injury) or to be killed each year (Kaufman 2006). This

would be unacceptable even if these drugs were dispensed under the best of circumstances. However:

Progress in the pharmaceutical sector accounted for only a tiny proportion of the hundred or so new products and indications analyzed by *Prescrire* in 2011. About one in six new products had more harms than benefits, while more than half of all new products provided no advantages over existing options. . . . There were numerous new products masquerading as innovations, mostly with harm-benefit balances that are no better, and sometimes worse, than those of existing treatments (*Prescrire International* 2012:106).

Table 14 shows *Prescrire International's* (2012:107) ratings of pharmaceutical products produced between 2002 and 2011 for their novelty and effectiveness.

Table 14. Ratings of new pharmaceutical products and indications between 2002 and 2011	
Rating	Percent of products (n=994)
Bravo (n=2)	0.2
A real advance (n=13)	1.3
Offers an advantage (n=61)	6.1
Possibly helpful (n=205)	20.6
Nothing new (n=517)	52.0
Not acceptable (n=148)	14.9
Judgement reserved (n=48)	4.8
Abstracted from <i>Prescrire International</i> 2012:107	

These data strongly suggest that like the insurers described below, pharmaceutical corporations tended to be self-serving while too many HCCs have become ensnared unwittingly by pharmaceutical organizations.

Insurer Business Orientations

Many Vineyarders viewed insurers as one of the largest impediments to accessing health care, largely because they viewed insurers as too business oriented. They often recognized that insurance (and pharmaceutical) health care power brokers were

instrumental in keeping health care costs high. These high costs included financial costs, human costs, and costs to communities.

To be sure, insurers do not ration health care by decree. Because primary health care is beyond the means of many and hospital care is beyond the means of most Americans, *de facto*, health care is rationed if it is not adequately covered by an insurer. Some health care professional and HCC study participants lamented that, because insurers rarely reimbursed alternative health care providers, not all Vineyarders could afford alternative health care services. Some claimed that their insurers had recently begun to cover a small number of such health care modalities. A majority of alternative health care professionals claimed that not being reimbursed by insurers was beneficial because it greatly reduced their bureaucratic burdens. Also, some claimed that, if they were to accept health insurance, they would have raised their prices because they would have had to either work fewer hours with patients and submit insurance forms or hire someone to complete such forms.

Many Vineyard HCCs underwent the rationing of their health care services when they used (or tried to use) mainstream health care services. Methods of health care rationing included insurer rationing by inconvenience, insurer “cherry picking,” and health care organizations buying into insurer incentives to ration health care. Insurers promoted health care rationing by inconvenience when they drove up their policyholders’ health care costs and when they produced difficult and tedious requirements for health care professionals and their insured HCCs.

Insurers rationing of health care of a population with huge disparities in wealth played a significant role in Vineyarders' uneven access to health care. Roughly speaking, study participants, other Vineyarders, and archival data suggested that Martha's Vineyard health care was three-tiered. These tiers were health care services for the elite few and for the non-elite who could pay and who could not pay. "Elites" are members of that stratum that holds the most prestige and the most influence over society (Theodorson and Theodorson 1969:129).

Many Vineyarders described their self-rationing of health care services to avoid insurmountable debts that could accrue if they were to obtain health care. Among these Vineyarders were several who held health insurance. Like Americans overall (Rank, Yoon, and Hirschl 2003:4), some Vineyarders tended to view poverty and difficulty paying for health care "as an individual failing" (Rank, Yoon, and Hirschl 2003:4). Other Vineyarders viewed difficulties paying for health care as a health care system failure. Vineyarders' fear of crushing debt and humiliation and shame stemming from the inability to afford health care or to pay one's debts provided a major incentive to avoid using health care services. Vineyarders found health care debts were particularly threatening because they could have economically forced them to relocate to the mainland. Some (included those with health insurance) claimed they avoided health care or skirted their health care debts because they were not willing to give up their homes, hobbies or interests. For many, insurers refused to pay for some health care procedures and required HCCs to pay a significant portion of their health care costs. Kay Lazar (2009:B-1) claimed that at least one million Massachusetts residents were expected to

spend ten percent of their incomes (before taxes) on health care in 2009. Massachusetts's 2010 population was 6,547,629) (US Bureau of the Census 2012:2). Close to 300,000 were expected to spend more than a quarter of their gross incomes on health care. The majority (90 percent) of the study sample Lazar reported on possessed health insurance (Lazar 2009:B-1).

Several Vineyarders expressed their dissatisfaction with their insurers because, though they held health insurance, they claimed that their health care costs were too high or that they worried that they could have been bankrupted by health care expenses. Vineyarders claimed also that their deductibles were too high or their co-payments were unaffordable, especially if they used health care services often. A "co-payment" is an amount set by insurers that a policyholder pays to the health care provider at each visit. A "deductible" is a set amount one must pay annually for health care before one's insurer begins to reimburse his health care professionals for that patient's health care that year. Like other Massachusetts residents (Nardin, Himmelstein, and Woolhandler 2009:8), some Vineyarders could afford, often with difficulty, only catastrophic health insurance. Several Vineyarders who held such policies had never collected benefits because the plans had such high deductibles. Some suffered from their illnesses or worried that some undiscovered issue could, without an early diagnosis, lead to future problems.

The literature strongly suggests that insurers drove up health care costs not only for their underwritten but also for patients who paid out of pocket (see Polleys 1997). Tom Musco, Director of Research and Statistics for Health Insurance Association of America noted in a personal conversation (August 2, 2002) with Pryor et al. (2003:17)

that insurers promoted health care inflation and high hospital rates for private-pay patients in their efforts to maximize revenue from all sources. This is because insurers used hospitals' charges to private pay patients as a starting point when they negotiated insurer discounts (Pryor et al. 2003:17). Additionally, establishing high charges improved operating margins and promoted high bond ratings so hospitals could borrow money at lower interest rates (Pryor et al. 2003:vi, 17; Mahar 2006:143, 144).

“Cherry picking” helped insurers to avoid “adverse selection” (Thomasson 2002:2, 3; Blumberg and Nichols 1995:16) or that which occurred when unhealthy people had more incentive than healthy people to obtain health insurance (Field 2007:80; Blumberg and Nichols 1995:16; Geyman 2004:60 citing Kleinke 2001). The long history of insurer policies that, in their efforts to prevent adverse selection made it easy for the wealthy and others less apt to become sick and difficult for sickly and impoverished people to access health insurance (Starr 1982:334). Sightings (2012) argued that those who held plenty of wealth were less apt to become sick. Insurers had devised several methods to exclude those applicants who were sick or who were more apt to become sick or injured. Early 20th century insurers excluded people of high-risk groups when they charged them unaffordable rates. An inherent dilemma in health insurance plans was exemplified in that day's accident insurance:

Since the inception of scientific accident underwriting the rates have been based on occupational hazards, so that the person who is engaged in a nonhazardous occupation pays much less for his protection than the person who is engaged in hazardous work . . . The practical result, therefore, of this principle is that the person engaged in an occupation with little or no danger inherent in it can carry adequate protection, while to the person who is engaged in hazardous work, and to whom this protection is a necessity, the cost of such protection is almost prohibitive. It may be said, in fact, that the cost of adequate protection *is* prohibitive (Rhodes 1915:13, italics in original).

Employer-sponsored indemnity health insurance became widespread after World War II and enabled insurers to further cherry pick their pools of insured. Unhealthy people are less apt to work. Also, employer-sponsored health insurance tended to be offered to employees of those occupations whose members tend to hold little risk of needing health care. Such occupations included relatively well paid managerial, specialized professional and governmental employees (Oberlander 2006:247; Starr 1982:333; Enthoven and Fuchs 2006:1541-1542; Stoll and Bailey 2009:3; Akerlof 1970:494). Insurers' efforts to prevent adverse selection have dissuaded employers from hiring unhealthy people or older people (Akerlof 1970:493-494; Burman and Rodgers 1992:340). Insurers required that employers contribute some percentage of the cost of an employee's insurance policy (Claxton and Lundy 2008:7) and charged employers higher rates for underwriting older employees (Claxton and Lundy 2008:7). Hence, those in higher risk occupations, the unemployed, the sickly and the elderly fended for themselves. By the late-1950s, Harris (1966) noted that more than 85 percent of the elderly were uninsured (Bodenheimer and Grumbach 1995:13, 213). Insurers avoided the coverage of some conditions, such as mental health care, to discourage people with chronic illnesses

that promote the use of acute health care services from enrolling in their plans (Blumberg and Nichols 1995:18).

Insurers promoted job-lock and wedlock (for those who held insurance through their spouses). Job-lock and wedlock occur if one is reluctant to change jobs or to end a bad marriage for fear that it would be difficult to purchase comparable health insurance or to obtain health insurance through a new employer (Enthoven 2007:107; Chirba-Martin and Torres 2008:424; Stoll and Baily 2009:10-11 citing *Business Week* 2007 and Madrian 1994). Insurers required consumers to be evaluated by a physician before signing an insurance policy (Thomasson 2002:5) and thereby could be denied health insurance. Insurers required employees to wait for a period of time after being hired until the insurance policy was active (Claxton and Lundy 2008:7; Butler 1999:13). This put people at risk of the accrual of crushing medical indebtedness during the waiting period for a new insurance policy. Some Vineyarders claimed that the high costs for health insurance led them to decide their career trajectories instead of choosing a career or a position which they deemed more desirable. Some stayed at unsatisfactory jobs to maintain their employer-sponsored health insurance.

Around the time of the new millennium (Cohn 2010), cherry picker insurers became more emboldened. Not only did they pick their cherries but insurers pruned from the roots to end contracts with their underwritten whose exchange values proved to be disappointing. Insurers' practices included "rescission"³⁰ (canceling an insurance contract with a policyholder after one was diagnosed with a costly disease) (Potter 2009) and "purging" (canceling insurance contracts with groups of policyholders) (Potter 2011:73,

74-75). On Martha's Vineyard, insurers accomplished rescission or purging when they raised their rates for premiums. Some Vineyarders could no longer afford their health insurance. Such individuals discontinued their health insurance. Others switched to a less expensive insurer or to a catastrophic health insurance plan. Many among them claimed that soon after they switched plans, the insurer raised their rates.

Insurers may have threatened to cancel one's policy if a policyholder failed to meet an insurer's difficult to interpret requirements. This was the case for a Vineyarder who claimed that she was confused by MassHealth sending duplicate forms each time. After she believed she had completed the process, MassHealth sent letters that indicated she was required to send further information to prevent her coverage from being canceled. As on the mainland (Potter 2009), some Vineyard small employers reduced their employees' insurance coverage or changed their employees' insurance carriers after the cost of employees' insurance became too high. Like mainland ones (Peters 2007:265), some Vineyard employers discontinued providing insurance coverage altogether. National Small Business Association data show that in 1993, 61 percent of US small businesses offered insurance coverage. By 2009 only 38 percent offered insurance coverage to their employees (Potter 2009).

Because health care and health insurance are not affordable for those in the lower and for many in the middle economic echelons, insurers have *de facto* rationed health care when they implemented policies that prevented adverse selection. Thereby, insurers (in concert with health care providers who accepted insurance by insurers who conducted themselves in this manner) have significantly reduced the value of health care for

communities. Insurers' "corporate construction of reality" (Rylko-Bauer and Farmer 2002:489) was well-entrenched. Little meaningful public discourse had taken place though health care rationing tends to be a highly contentious issue in the US (Stein 1998:89; Potter 2011:204). Insurer policies of health care rationing tended not to be framed as such. Rather, federal and private insurers used the neutral language of rational accounting while obfuscating their rationing of health care and while routinely and unfairly denying people health care (Shore and Wright 2005:8; Stein 1998:89; Imershein and Estes 1996:233). Power brokers use "political technologies," that is, the policy, the word or the metaphor as "an instrument of power for shaping individuals" (Shore and Wright 2005:4 citing Dreyfus and Rabinow 1982; Dreyfus and Rabinow 1983:134). Political technologies enable power to "mask a substantial part of itself" (Foucault 1980:86; Dreyfus and Rabinow 1983:134 citing Foucault 1980:86; Martin 1997:242 citing Foucault 1980:86).

Obscuring power made manipulation and subordination more tolerable, promoted a false sense of social stability within a dysfunctional system, and obscured strategic alliances that forwarded health care power brokers' interests in spite of their consequences for the public good (Rylko-Bauer and Farmer 2002:489-490; Stein 1998:79). Insurers formed their policies to limit insurer risks, decrease insurer costs, maximize insurer benefits, and ultimately, to further insurers' profits (Randall 1994:4-7, 20; Spector 2004:284; Geyman 2004:67). They have obscured employer-sponsored insurance's high costs. Few Vineyarders claimed that a negative consequence of their possessing health insurance was its high costs. Many Vineyarders who held employer-

sponsored health insurance claimed that they did not feel the impact of the costs of their health insurance because their insurance payments were automatically deducted from their paychecks.

Those industries that rated the lowest in consumer satisfaction, retail and wholesale (82 percent), social media (78 percent) and entertainment and arts (77 percent) (Savitz and Urlocker 2012:1) fared better than the 74.2 percent of Vineyarders who claimed that their health insurance was adequate in response to the question, “Is your health insurance adequate, somewhat adequate or not adequate to meet your health care needs?” Only three-quarters of HCCs (72.5 percent) and health care professionals (75.9 percent) claimed their health insurance was adequate to meet their health care needs (Table 15). This left approximately one-quarter of the HCCs and health care professionals who claimed their insurance was somewhat adequate, not adequate or that they did not know if it was adequate. If all study participants had used (or tried to use) their health insurance prior to their interviews, in all likelihood, a larger percentage would have claimed that they were dissatisfied with their insurers.

Table 15. Comparisons of percent of HCCs and health care provider, trustee, and administrator responses to “Is your health insurance adequate, somewhat adequate or not adequate to meet your health care needs?”				
Status	Is your health insurance adequate, somewhat adequate or not adequate to meet your health care needs?			
	Yes	Somewhat	No	Do not know
HCCs (n=109)	72.5	16.5	3.7	7.3
HCPTAs (n=108)	75.9	12.0	8.3	3.7
Total (n=217)	74.2	14.3	6.0	5.5

HCC=health care consumer; HCPTAs=health care practitioners (clinicians), trustees and administrators

Low satisfaction with insurers compared with other industries was not surprising given insurers' business plan of alienating their clients from utilizing their insurance benefits and of alienating health care professionals from advocating for their patients. Insurers' bureaucratic demands started on Martha's Vineyard when managed care insurance policies were introduced. Many HCC and health care professional study participants expressed much frustration when recalling their dealings with insurers. They often blamed insurers for producing a complicated health care bureaucracy that was difficult to negotiate and for preventing health care professionals from obtaining payments for services they planned to provide or had provided. Some Vineyarder health care professionals did not fill out insurance forms but placed that burden on the HCC.

Like mainland employers (Oberlander 2005:14; Peters 2007:264), Martha's Vineyard employers, including MVH (D'Ambrosio 1999d:1) switched their employees to managed care insurance after insurance companies charged lower rates than they charged for indemnity insurance. Perhaps the employers neglected to take into account that Vineyard physicians (and many Vineyard pharmacists (D'Ambrosio 1999d:1)) did not accept managed care insurance. Perhaps insurers instituted (by offering it at lower costs) managed care on the Island to promote self-rationing of health care. Until Vineyard physicians began accepting it, Vineyarders who had managed care health insurance were required to travel to the mainland to use their health insurance benefits for primary physician care.

Many Vineyarders claimed such insurer limitations and bureaucratic impediments promoted health care professionals to limit the health care they provided, especially if it

were care that they expected would not be reimbursed. Additionally, the time they spent wrangling with bureaucrats over whether the insurer would cover the costs of the health care took away time they spent at the bedside. A longtime Vineyard physician claimed that physicians' time spent convincing an insurer that a referral to a specialist or some other action was necessary was an impediment to resolving a shortage in physicians. He stated that before managed care, a physician was able to see more patients in a day. Further, some health care professionals claimed that being a health care professional became significantly less enjoyable thanks to the tedious tasks necessary to appease insurers. Vineyard health care providers lamented that health insurers often required them to resubmit forms after the insurers claimed they had lost them or had never received them. All but one mental health care practitioner study participant claimed that insurers made it more difficult for them to receive health care reimbursements compared with those of other health care specialties. The one mental health professional who had not found insurers to be problematic had hired someone to fulfill this role. Several health care providers claimed that hiring personnel to meet insurers' bureaucratic mandates led to health care resource waste.

Several HCCs claimed that their health care professionals gave up trying to gain reimbursements hence would not provide the health care unless the HCC managed to gain an insurer's agreement. Several HCCs claimed that they did not possess the time or energy to telephone insurers or to complete lengthy, tedious, and difficult to interpret bureaucratic requirements to generate insurer payments for their health care. It is likely Vineyarders had more difficulty finding time to generate insurer payments because

Vineyarders tended to spend more time working than mainlanders. Also significant is that several HCCs claimed that information insurers provided was unreliable. Hence, they feared using health care services though the insurance bureaucrat claimed it would be covered. One claimed that the health insurance bureaucrat appeared too uneducated for her role. She asked rhetorically how could such a bureaucrat who pronounced “birthday” as “burfday” be credible.

Health Care Provider Adaptation to Insurer-managed Care

Rather than mobilizing against insurers exploiting them, health care practitioners rationed health care in response to insurers reducing their reimbursement rates. They reduced their time interacting with patients and filled their schedules with a larger number of patients in their efforts to maintain their incomes. Such insurer perverse incentives destroyed opportunities to interact with patients. Such interaction often provided job satisfaction and helped to uncover important health issues.

Unlike those enrolled in concierge physician practices (discussed later), time constraints prevented some HCCs from expressing their concerns during medical interactions. Use of the word in health care encounters could have significant consequences. Words can motivate us to take actions or to form attitudes (Cohen 1985:14). For centuries, people have claimed that the power of the word is significant. West and Loomis (1999) argued that “the ability to define the alternatives is the supreme instrument of power” (Quadagno 2004:29). William Shakespeare claimed “The pen is mightier than the sword.” Saint John (1:1) opens the *Holy Bible* with the claim that “the

Word” possesses ultimate power: “In the beginning was the Word, and the Word was with God, and the Word was God.” This begs the question, “if all words are symbols, and we construe our perceptions with words, what *really* exists?” Here, an ontologically neutral perspective is used rather than pursuing this question. For Justus Buchler (1990:32), an ontologically neutral perspective abolishes “any inference, from A’s being . . . more or less real, of greater or lesser being, than something else.”

Study participant HCCs suggested or claimed outright that clinicians who patiently enabled them to frame and express their narratives promoted more effective healing than those who showed little interest in or patience toward hearing patients’ stories. The therapeutic value of sharing stories was known among indigenous healers who:

work through story. They tell stories—mythical, legendary, and personal. They encourage the person who is suffering to tell his or her story. . . . the healer helps the person change his or her story (Mehl-Madrona 2005:151).

An overemphasis on business-orientations and reductionist thinking precluded health care professionals from putting stock into patient narratives. Rather, an anthropologist who conducted participant observation as a medical student found that “Words exchanged with the patient were basically viewed as tools to make . . . procedures go more smoothly” (Konner 1987:25). He claimed that more often, his professors promoted poor medical student and patient interaction (Konner 1987:38, 56). Medical students were being socialized to focus only on the physician’s definition of a patient’s immediate medical concerns. Their conversations with patients were limited significantly by physician-directed brevity (Mizrahi 2008:218, 220, 221; Mizrahi

1986:93, 113, 114 ; Stoller 2004:52). Managed care furthered such pressure on physicians. Physicians:

were constantly beset by demands that they reduce costs, they could not feel encouraged to linger with their patients over details that were not immediately essential. Yet such details could turn out to be life-saving in the near term and highly cost-efficient for the future (Konner 1987:33).

Perhaps it was pressure from too large a patient load that led Vineyard physicians to silence some study participants with harsh words. One tearfully claimed that she waited 18 months to seek another health care provider after a Vineyard physician did not take her complaint of *chest pain* seriously. Thanks to Island Health Care (IHC) having opened, she addressed her chest pain there and found that Lyme disease had inflamed her sternum. That Martha's Vineyard was regarded as a "hot spot for tick-borne illnesses" (Sigelman 2006:6) strongly suggests that this physician either was grossly incompetent or had a bad attitude toward her (or both). She claimed that the physician laughed at her. Another Vineyarder claimed that while suffering postpartum depression and shedding tears, her obstetrician exclaimed, "What are you crying for?!"

Some Vineyarders buttressed Paul Stoller's (2004:54) claim that a physician may act as if the patient's time is irrelevant and the physicians' time is all-important. For example, a Vineyarder claimed that though she had previously endured long waits at her physician's office, she was required to reschedule her mammography screening after being just six minutes late for her appointment. Another claimed that though her husband's physician sometimes made her husband wait 20 minutes, her husband was required to reschedule his appointment after being 15 minutes late.

Perhaps unwittingly, some physicians prevented some patients from opportunities to schedule appointments. Some study participants who worked in lower echelon jobs claimed that one of their difficulties accessing health care was a result of the closing of Vineyard physician offices during the lunch hour. Lower echelon workers could make telephone calls only during their lunch breaks. Their lunch breaks coincided with the physician office staff's. Such workers were not allowed to make telephone calls while working. It was uncertain if this pointed toward physicians closing their offices during the lunch hour in an effort to exclude working class patients. Other reasons could have been to avoid the interruption of work routines that could ensue if not all employees were present or to promote employee morale through the opportunity to dine together.

Health care providers rationed health care at an HCC's first contact. Several Vineyarders claimed that the first question a physician receptionist asked when one called for an appointment was, "Do you have health insurance?" A "yes" response to that and the "correct answer" to the inquiry, "Who is your insurance carrier?" were the keys to entry into the physician's appointment book. Without these keys, it was likely a physician did not accept the patient into his practice. A patient was more apt to ascertain that the door stay open for future visits if the health care provider received adequate reimbursement for that patient's care.

As some Vineyard HCCs and health care professionals pointed out, if a patient's debt to his physician was increasing too much, some physicians did not accept that patient again until the balance was paid (or a payment plan was started). Some physician staff embarrassed patients into paying for their services. They asked the patient within the

earshot of people in the waiting room to pay what they owed. One claimed her teenage son was “devastated” upon leaving the physician’s office when a receptionist stopped him and made such an inquiry. Such efforts at embarrassing patients into paying likely would have been less effective in places where people tend to be more anonymous.

Some Vineyarders harked back to the day old-fashioned US country physician predominated such as those (likely imagined) of the 1950s. The literature (Carter 1958; *Yale Law Journal* 1954) claimed that physicians’ self-motivation was not absent during the 1950s. An elderly Vineyarder buttressed such literature when she recalled, that while her children were young, she had difficulty paying her Vineyard family practitioner. As her debt mounted, she claimed that “chills ran up her spine” when her physician threatened that serious consequences could ensue if she had continued to avoid paying for his services. She had understood that to have meant that her children could have been denied health care services, even if seriously ill. More recently, an alienated Vineyarder who had been diagnosed with depression and bipolar disease claimed a mainland physician drove him away by his poor demeanor and his refusal to prescribe what he had asked. He claimed that he enacted revenge. He sued. Though he lost the case, he claimed he was satisfied because the physician was required to waste time in court.

Martha’s Vineyard Hospital and other hospitals that accepted Medicare payments were legally mandated to screen and stabilize all patients who entered its emergency department with an emergency medical condition regardless of their ability to pay (Centers for Medicare and Medicaid Services 2012). From the perspective of Vineyarders who were excluded from adequate emergency department care, this was

simply an “oratorical abstraction” (Cohen 1985:13). Some Vineyarders who had no health insurance claimed that some MVH emergency department physicians minimized their diagnoses to legitimate the need for fewer treatments or the lack of criteria to be admitted to the hospital. Some who had used MVH emergency department services claimed that a small number of its physicians were more friendly than others toward providing adequate care to those without insurance. If MVH turned away the downtrodden, for whom does it exist?

Health Care That Attracts Vineyard Elites

Elite Vineyarders were powerful, middle aged and elderly philanthropists who had amassed wealth from their occupations, investments or inheritances. Vineyard elites had no difficulty affording topnotch health care and topnotch health insurance. A Vineyarder claimed that Vineyard elites could avoid waiting for an appointment on Martha’s Vineyard because they could fly their private planes or charter an airplane to an off-Island health care provider. One elite study participant claimed that he was uninsured because health insurance was not worth what it would cost. Also, he claimed that he could afford any possible health care.

An MVH trustee suggested that MVH existed for elite Vineyarders. This trustee (Sandy Ray) claimed that if Martha’s Vineyard did not have a hospital, “many people would not be living here That would change the entire economic landscape” on Martha’s Vineyard (D’Ambrosio 1999b:19). In all likelihood, Ray was referring to a change in Martha’s Vineyard’s social and economic landscape if an exodus of Martha’s

Vineyard elites were to occur. Elite and other middle-aged and elderly Vineyarders likely would not have desired to vacation or own a second home in an isolated place if modern health care facilities were not available there. If Vineyard elites were to migrate elsewhere, they would no longer donate to Vineyard nonprofit organizations and Martha's Vineyard elite social statuses would be downgraded. Many if not most of the cultural events for elites would no longer take place on Martha's Vineyard. This would diminish opportunities for elites' social networking, name dropping, and fund-raising. If a large enough number of elites were to cut their Vineyard ties, a collapse of Martha's Vineyard real estate values would further diminish Vineyard elites' statuses. It would lead medical specialists to migrate to somewhere with a "good" patient population. A good patient is one whose health care generates profits (Grossinger 1995:55).

Martha's Vineyard Hospital's possession of up-to-date medical technology helped maintain Martha's Vineyard as a highly sought destination for elites. Martha's Vineyard Hospital officials publicly announced their newly acquired technologies. According to MVH's CEO, MVH "invested over one million dollars" (Walsh 2002:2) in diagnostic imaging equipment (a CT scanner, prenatal and cardiac ultrasound machines and a bone densitometer) (Walsh 2002:2). In 2006, MVH purchased laproscopic equipment and expanded its colonoscopy services (Goldfein 2006:3). The new MVH building had "operating rooms with advanced technologies [and a] radiology department . . . equipped with the best technology available" (Pil 2011:3, brackets added).

Since the early-20th century (Rosenberg 1987:333), hospitals have "sought to capitalize on their image as temples of science" (Rosenberg 1987:333) that hold

mysterious and sophisticated tools (Rosenberg 1987:333). Such tools were advantageous because they produced potential for health care organizations to charge a good deal for services and for clinicians to gain technological experience (Shi and Singh 2010:118-119 citing Ingelhart 1982). Medical technological tools drew patients and specialists to health care facilities that provided costly specialist services (Shi and Singh 2010:112; Chirba-Martin and Torres 2008:425). The high costs for them helped insurers to legitimate charging high premiums (Carter 1992:213).

Putting such great stock in the use of medical tools could be viewed as “a vast cultural delusion” (Mahar 2006:188). Studies have shown that medical technology (including CT scans, ultrasounds, nuclear scans) had not led to accurate diagnoses being made more often. However, this failure was found to lie, not in the technology, but in the physicians who failed to consider diagnoses that would have had led them to ordering the appropriate diagnostic tests (Gawande 2002:198). According to Atul Gawande (2002:197), a study of autopsies showed that since 1938, misdiagnosis rates had not improved. Physicians reviewed 1960 and 1970 Harvard Medical School autopsy records before modern diagnostic technologies were part of medicine’s arsenal and found no improvements in 1980 after such technologies were being widely used (Gawande 2002:197). In three studies conducted in 1998 and 1999, the error rates were approximately 40 percent (Gawande 2002:197).

Like MVH, Martha’s Vineyard’s concierge medical practice made Martha’s Vineyard a more desirable destination for its wealthy summer home owners. Two Martha’s Vineyard emergency department physicians had set up a summer concierge

physician practice in 2006 (Hefler 2008:9). Such a practice helped to promote Martha's Vineyard as an attractive place for those Vineyarders who were willing to pay for quickly accessible and more personalized physician services. Martha's Vineyard concierge physicians resolved their patients' difficulties obtaining primary health care during summers while Vineyard physicians were stretched thin. Table 16 compares kinds of medical practices. It shows the number of patients per physician on Martha's Vineyard (in 2000) during and after summer and in the US overall (in 2002); patients per physician in US and Martha's Vineyard concierge medical practices in 2006; and patients' costs who enrolled in these practices. In the US overall, internist physicians outside concierge practices covered between 2,500 and 3,000 patients (Knope 2008:12).

	Place		Season		Patients per MD	Cost/year to join
	MV	US	Summer	Year-round		
MD	■		■		4,232	\$0
MD	■			■	2,286	\$0
MD with HAP	■			■	1,778	\$0
Concierge MD	■		■		**	\$7,500
Concierge MD		■		■	50 Fs to 600 pts	\$1,500 to 18,000

Fs=families; HAP=hospital admitting privileges; MD=Medical Doctor (physician); pts=patients; **number not available
 Abstracted from John Snow, Inc. 2000:3; Knope 2008:12-13.

As in other kinds of primary care physician practices, concierge practice patients were billed for medical services they used. Concierge patients in the US also paid annual fees (shown in Table 17) that ranged from \$1,000 to \$20,000³¹ in 2002 (Rylko-Bauer and Farmer 2002:485 citing Brennan 2002). Patient fees for joining Martha's Vineyard's concierge practice precluded all but wealthy Vineyarders from accessing concierge

medicine. Martha’s Vineyards’ concierge physician roster included patients who received no physician services to those who received them once a week during the entire season (Hefler 2008:12).

Table 17. Costs per summer for Martha’s Vineyard concierge medical practice	
Coverage	Annual (summer) cost
Individual	\$7,500
Individual plus one	\$12,000
3 to 5 member family plan	\$15,000
Additional family member	\$1,000 each
Source: Hefler 2008:9	

Providing concierge medical services was an antidote to physician burnout. A Vineyard physician stated that concierge medical practices provided physicians opportunities to practice medicine as it should be practiced. As Table 17 shows, while upper end mainland concierge physician rosters included approximately fifty families, lower end ones included approximately six hundred patients. The Vineyard concierge physicians were slowly taking new patients to gain a sense of what maximum number of patients it would include (Hefler 2008:12). This was likely because they desired to gain a sense of the number that would work best for their practice while balancing their family lives and their employment elsewhere.

The resolution of wealthy Vineyarders’ difficult access to local Martha’s Vineyard primary health care and the promotion of health care technologies to signify Martha’s Vineyard’s desirability for summer home owners and Vineyard visitors can “trickle down” somewhat to others. The physician appointments not filled by a wealthy Vineyarder who instead uses Martha’s Vineyard concierge physician services would enable another to fill that appointment. Attracting Vineyard elites through use of up-to-

date health care technologies enables some non-elites to gain access to such services. However, such efforts have done little to resolve the difficulties many Vineyarders experienced.

RomneyCare Mandate that Individuals Bear Responsibility for Health Insurance

Some Vineyarders claimed that they believed “RomneyCare,” or that which they more often referred to as “the new health insurance legislation” or “the health insurance mandate,” was a positive step toward universal access to health care. While a majority of Vineyarders recognized the value of adequate health insurance, some uninsured study participants and other Vineyarders anticipated difficulties affording health insurance under the RomneyCare mandate or viewed health insurance as a waste of money because it tended not to cover alternative health care.

Like US political office holders who formulated policies on behalf of large campaign donors (discussed in Chapter 4) rather than on behalf of their constituents, insurers promoted and benefitted from a system that enabled prioritization of one’s ability to pay over one’s need for health care (Hoffman 2010:8, 59-60). The heavy emphasis on individualism in the US had promoted a fragmented system of health care finance that was at risk of collapse. An example of such potential is an insurer-promoted “death spiral,” or more specifically, a US health insurance market “adverse selection death spiral” (Hoffman 2010:28). Insurers had driven up health insurance costs so much that they drove not only impoverished and sick people, but also low-risk policyholders from the health insurance market (Hoffman 2010:19, 60, 28). This increased the percentage of

unhealthy policyholders whose health care could cost more than their health insurance premiums. This problem was further exacerbated because insurers continued this downward spiral and drove up health insurance costs further (Hoffman 2010:28). This and increasing health-insurance-for-all advocacy (Nardin, Himmelstein and Woolhandler 2009:3) had led to more collectivistic (by US standards) resolutions, or what Soumerai, Koppel, and Bolotnikova (2017) referred to as a “‘Hail Mary’ effort” toward alleviating Massachusetts’s health care financing crisis.

The federal government’s lack of effort to resolve America’s health care crisis had led Massachusetts to take steps toward alleviating it (Chirba-Martin and Torres 2008:409-410, 427). Former governor, Mitt Romney signed the Massachusetts individual health insurance mandate legislation in 2006 and its implementation began in 2007 (Chirba-Martin and Torres 2008:410). This law mandated that most Massachusetts residents obtain health insurance and that the commonwealth subsidize insurance policies for those within lower income brackets and other high-risk populations that previously could not obtain health insurance (Chirba-Martin and Torres 2008:415; Hoffman 2010:62, 62 note 287; Hirschorn and Glor 2012). Employers who did not pay at least a percentage of the costs of their employees’ health insurance policies and uninsured residents who did not purchase individual health insurance were required to pay an annual fee when they filed their income tax forms (Hoffman 2010:69; Nardin, Himmelstein, and Woolhandler 2009:3, 4; Chirba-Martin and Torres 2008:414, 421). Those employers who employed ten or fewer full-time employees and 20 percent of low-to moderate-income, uninsured residents were exempted from the mandate (Chirba-Martin and Torres 2008:419, 426).

Those whose taxable incomes were at equal to or less than 300 percent of the federally-designated poverty level were either exempted or could purchase government-subsidized health insurance (Chirba-Martin and Torres 2008:426; Tanner 2006:25).

On one hand, the literature suggested that individual mandate legislation was a resounding success. By 2012, Hirschorn and Glor (2012) claimed that only two percent of Massachusetts residents had not possessed health insurance whereas it was ten percent before the legislation. A few years later, Josh Archambault and Jim Stergios (2016) asserted that the percentage of uninsured had been reduced from nine to three or four percent. Perhaps these different rates were a result of the mandate's diminishing success. It is equally plausible that the rates differed as a result of different study methods, different population samples, researcher biases or other factors. This legislation enlarged the number that paid insurance premiums, co-payments, and health care costs that insurers did not cover. Prior to this legislation, these patients would not have been charged (Nardin, Himmelstein, Woolhandler 2009:2). Whether one would view this as a success or a failure would depend on if one believed that people should be able to obtain health care only if they pay for it.

For those whom the opinions held by 72 percent of Sonali Saluja et al.'s (2016:185, 187) 1,151 adult, non-elderly study participants obtained from three safety-net hospital databases held weight, this reform failed. They were surveyed to compare their opinions of their experiences with safety-net health care services seven years after this reform was passed with experiences they believed would have transpired had universal access to health insurance been enacted. "Safety-net providers" are those public or

nonprofit hospitals and community clinics that provide emergency, primary and chronic mental health care to the uninsured and others who experience difficulty accessing health care (National Association of Public Hospitals and Health Systems n.d.:1; Nardin, Himmelstein, and Woolhandler 2009:2). The legislation did little to improve health care access in general and made access more difficult for those who were affected by the reduced safety-net hospital government funding (Nardin, Himmelstein, and Woolhandler 2009:2, 11).

The literature suggests that the insurance mandate failed because it had done little to address high health care administrative costs and HCCs' health care expenditures (Chirba-Martin and Torres 2008:425; Nardin, Himmelstein, Woolhandler 2009:2, 8). Nardin, Himmelstein, and Woolhandler (2009:2) claimed that the amount (\$8 to \$10 billion annually) wasted on administrative costs could have been allocated under a single insurer plan to cover health insurance for all uninsured Massachusetts residents and to significantly reduce out-of-pocket health care expenses for insured residents. Archambault and Stergios (2016) claimed that virtually no changes had been noted in the percentage of Massachusetts residents who reported that they had experienced difficulty paying their medical bills. This, long waits for a physician appointment and difficulties among the insured to find a physician who accepted new patients likely were significant factors that led to those more than half within lower income groups to report that they had not received necessary health care in 2015 (Archambault and Stergios 2016). Many of them held government-subsidized insurance policies. These lackluster gains were achieved at a high cost to the state. Only 17 percent of the newly enrolled had not

purchased their health insurance through a publically funded program (Hirschhorn and Glor 2012).

Allison K. Hoffman (2010:13) argued that an individual health insurance mandate would do little to resolve health care access problems unless health insurance legislators mandate the equitable provision of health care services, health insurance access, and policyholder benefits. An equitable distribution of these would hold potential to produce significant benefits such as medical need being the basis for the distribution of health care resources and the end of medical bankruptcies (Hoffman 2010:31, 32, 38). RomneyCare legislation did little to address such concerns. It reduced differences in percentages of costs for insurance premiums but still enabled a doubling of costs for some who purchase the same plan (Hoffman 2010:65). It enabled insurers to charge policyholders on the basis of experience ratings by a reduced number of factors but still allowed ratings by age, geographic location, and the size of the pool of insured (Hoffman 2010:65). Under “community ratings,” policyholders within an geographic area were charged the same rates, health insurance premiums were pooled, and insurers paid catastrophic medical costs with premiums obtained from those who seldom used their insurance (Madison 2005:59, 61; Hoffman 2010:11). Such risk spreading is almost nonexistent under an experience rating system that charges different rates to different subgroups according to their actuarial risks and according to the size of the insurance pool (large or small group or individual) (Madison 2005:59, 61; Hoffman 2010:12-13, 59). Under such a system, young and healthy people’s premiums no longer provided funds to cover health care costs for older and sicker policyholders (Geyman 2004:66-67 citing Kuttner 1999 and Aaron

1996). The lack of resolution of the uneven distribution of such benefits is not surprising. Insurers defined the terms of their contracts with policyholders and based these terms on actuarial data (Hoffman 2010:12, 64).

Community Efforts that Mitigated Harsh Conditions for Accessing Health Care

Archival and interview data described individual health care professionals and health care organizations that had mitigated Vineyarders' difficulties accessing health care. They did so through the implementation of formal or informal policies.

Community intimacy could explain the mitigation of some of the harsh effects for those who could not access health care. Community members who knew of one another promoted Vineyard health care professionals to provide community-oriented health care and Vineyard HCCs to expect such health care. Common Martha's Vineyard social networks provided a sense of a shared community consciousness. Health care professionals sometimes put forth their best efforts if they knew they were part of another's network by a weak (Granovetter 1973:1378) or a strong tie. A Vineyarder pointed out that a weak tie could be a source of pressure to improve one's health care provision. She claimed that she pressured an MVH nurse when she pointed out a shared social tie that motivated the nurse to improve her attitude toward this Vineyarder's hospitalized loved one.

Several HCCs provided examples of community-oriented Vineyard health care professionals who provided services that were not typical of their job description duties. For example, two nurse study participants claimed that during their day off, they gave

their patients rides to the mainland. A physician claimed that he paid a patient's bus fare. These actions enabled these patients to receive health care from mainland specialists. Some Vineyard physicians saw their patients while off duty or provided *pro bono* services informally or through the Vineyard Health Care Access Program (VHCAP). A Vineyarder expressed gratitude toward a pediatrician who helped her to access a mainland specialist within a week instead of a two-month wait.

Some Vineyard physicians had maintained the tradition of making house calls. Yet, many Vineyarders claimed that Vineyard physicians did not make house calls and attributed house calls to old-fashioned country physicians who had fallen out of existence. Old-fashioned country physicians often followed their patients from birth to death at their patients' homes, in their doctors' offices, and during patient hospitalizations. A shift occurred where Vineyard and mainland physicians desired ending their eight-hour working day until the start of their next working day. Unlike physicians of preceding generations whose patients summoned them when needed, Vineyard physicians who made house calls did so only at appointed times. One said she enjoyed her weekly house call drives to Aquinnah (from one of the down-Island towns). At MVH grand rounds, a physician provided a touching account of her all-night bedside vigil with her patient (a progeny of wealthy Vineyarders) until the patient died.

Unlike these willing volunteers, some visiting nurses claimed that they often were forced to donate their time to patients. To avoid performing these "donations," they would have been required to provide substandard nursing care. These nurses found themselves in this situation because their agency assigned too little time for each patient

visit to allow adequate care provision. They stayed significantly longer times than the hours for which they were paid. Some claimed that after enduring years of such pressure, they refused to work where they would be regularly required to do work for which they were not reimbursed (while also receiving relatively low wages).

Efforts Health Care Organizations Made to Include and Exclude Vineyarders

Study participants, other Vineyarders, and archival data portrayed many, if not most, of Martha's Vineyard's health care providers as having mitigated difficulties accessing health care for some or all of their patients. Four Martha's Vineyard health care providers' actions suggested strong commitments toward providing health care regardless of a patient's ability to pay. Hospice provided all its services free of charge. Hospice refused to accept payments from insurers. It depended solely on philanthropic funds. The only way to recompense Hospice would have been to make a freewill donation to Hospice. Hospice was one of the very few providers of its kind anywhere in the US that operated entirely without funding from either government or private health insurance companies (*Martha's Vineyard Times* 2005:6).

Not accepting payments from insurers enabled Hospice to provide services without taking into account health insurers' rules. This enabled Hospice to widen its scope of patients, and to prevent delays in patients seeking Hospice services (Schlossberg 2011:1; Waring 1999:32; *Martha's Vineyard Times* 2005:6; Wolfson 2004:4). Unlike most hospices, to have been a Hospice patient, one was not required to have a prognosis of six months or less to live. Some health care professional study participants argued that

not accepting Medicare limited Hospice care because it prevented Hospice patients from using their Medicare benefits to, for example, obtain insurance coverage for durable medical equipment (e.g., hospital beds and oxygen) and end of life (palliative) medications.

Like Hospice, one of Martha's Vineyard's four ambulance organizations showed a strong commitment toward promoting ease of access to its services. These organizations put health care orientations before business orientations because they did not pressure patients who did not pay. This ambulance service committee waived a payment if an individual simply claimed hardship. For those who did not claim hardship, this ambulance organization made no further efforts to collect a payment after a second bill remained unpaid. These policies prevented people from feeling pressured by continued reminders of their unresolved indebtedness.

According to an ambulance official, these policies were in effect to prevent people from being afraid to summon an ambulance. Such fear was founded. A Vineyarder claimed a Martha's Vineyard ambulance organization waived her payment. The ambulance organization official, who claimed he waived the charge because she had initially refused the service, added that any future ambulance bills would not be waived. Hence, she claimed, she would fear calling an ambulance if it were necessary to rush one of her young children to the hospital. Though she likely would have called an ambulance if her child were in dire need, she would have been burdened with added stress in an already extremely stressful situation. Also, serious consequences could ensue if consideration of costs were to cause her to delay summoning an ambulance.

Island Health Care and Family Planning of Martha's Vineyard (FPMV) officials showed a significant commitment toward their HCCs. They allowed uninsured and under-insured patients to decide the amount they paid. They requested payments at the time of service, the only window of opportunity one claimed, to collect a payment. Patients who could pay little and were allowed to choose how much they paid were able to maintain their integrity. They could pay for IHC's services without becoming impoverished and would not have received bills that would have been difficult to pay.

A Vineyard Nursing Association (VNA) official claimed that rather than dunning patients for money, the VNA geared its efforts toward collecting from and obtaining higher reimbursement rates from third party payers. Rather than dunning individual patients they knew, they sought higher payments from the more anonymous US Center for Medicare and Medicare Services. After a Martha's Vineyard visiting nurse agency spent a good deal of time, its efforts to lobby Medicare for higher rates brought an 11 percent increase in Medicare reimbursement rates (*Martha's Vineyard Times* 2006b:8; *Vineyard Gazette* 2006b:6).

Many Vineyarders viewed health care organizations that charged sliding fees as holding significant commitments to the improvement of access to health care services. Several study participants claimed that they brought their evaluations a notch higher (say from very good to excellent) for such organizations. Sliding fees (based on a patient's income) ranged from \$0 to full payment (Vineyard Nursing Association, Inc. n.d.; Martha's Vineyard Community Services n.d.). Vineyarders tended to view charges

according to a sliding fee scale based on income as more fair toward the patient than charging all patients, rich and poor, the same high rates.

The most frequent claim by those few who criticized sliding fees was that it was unfair that those who worked “under the table” or who did not report their entire incomes to the Internal Revenue Service could qualify for reduced fees. Sliding fees were based on a patient’s taxable income. A small number claimed that documenting one’s income and processing the applications added tedious, time consuming bureaucratic layers or could produce breaches in an applicant’s confidentiality. One study participant claimed that such a breach occurred by a Martha’s Vineyard social worker who took bribes for disclosing clients’ financial statuses to interested relatives. (This social worker was not employed by any of the health care organizations discussed in this dissertation). Study participants added that sliding fees that were determined uniformly according to taxable incomes could be problematic because one’s income may not have provided an accurate measure of need given possible extraneous expenses or unusual situations. Significantly, under the sliding fee system, visiting nurse service recipients were required to spend down their resources before they could qualify for reduced charges. Some Vineyarders claimed that spending down one’s assets before one qualified for Medicaid or for reduced visiting nurse charges (Centers for Medicare and Medicaid Services 2010:24; Commonwealth of Massachusetts Executive Office of Health and Human Services 2015:8-11) was a painful process.

Some Vineyard health care organizations had institutionalized accepting less than their full charges. Nearly all Vineyard physicians reduced their fees for some patients

through a program (*Vineyard Gazette* 2000a:1A) discussed in Chapter 3 or informally (not through a program). Martha's Vineyard Hospital reduced its charges to some who claimed hardship or accepted less than the full amounts if they made full payments right away. Such a lump sum payment was beneficial to MVH because it received the payment from a patient who might have stopped making incremental payments and, of course, they could receive the money sooner rather than later.

Martha's Vineyard HCCs buttressed health care providers' statements that few of Martha's Vineyard health care organizations pursued payments from all patients. Only one Vineyard physician study participant claimed he viewed health care as a commodity and did not reduce his costs for anyone. All HCAs claimed they avoided pursuing payments from some after considering a patient's circumstances and would not have discontinued an indebted patient's services if that patient was honest and "really" could not pay.

Collecting Balances Due

Martha's Vineyard health organization officials claimed that their health care organizations' billing officials used their discretion (within the bounds of health care organizational policies) when making decisions such as whether to waive some or all of a patient's charges or to use heavy-handed collection approaches. An MVH official claimed that Vineyarders had complained that MVH billing department officials pursued payments too aggressively. However, this official believed it was fairly done. It appears

that MVH motivated the person in charge of collecting payments because it paid him less than those from whom MVH expected him to pursue payments.

Martha's Vineyard health care professional study participants tended to exhibit confidence in their knowledge of Vineyarders who deserved reduced fee or "free" health care and those who did not. Martha's Vineyard Hospital and visiting nurse organization officials used invidious comparisons (Veblen 1994:34) to determine which patients deserved to have their charges waived. Visiting nurse study participants claimed that they were particularly advantaged when they made assessments to determine which patients failed to report all of their earnings in their applications for free or reduced cost health care.

Some health care professional study participants expressed resentment toward members of certain populations who received free health care. Some rejected Brazilian recipients but more often they rejected, in general, those patients who they believed had not declared all of their income. One HCA, three nurses and several HCCs expressed resentment toward those middle class or wealthy people who had qualified for free health care but did not obtain health insurance or did not pay their bills. This was the case especially toward those who owned valuable possessions (e.g., new car, boat, large screen television) or who spent lavishly on alcoholic beverages, illicit drugs or having expensive parties. One claimed that not disclosing one's income and thereby, being eligible for public benefits led to scarce health care resources being mis-allocated. This reduced the availability of public benefits for the "truly" impoverished. Another claimed that owners of larger Martha's Vineyard businesses who did not provide health insurance to

employees and did not report payroll expenditures also abused the public benefits system. In a nutshell, Vineyarders suggested that for the free health care system to have worked “as it should have,” all parties should have “played by the rules.”

Vineyard HCA study participants claimed that they lacked mercy for patients who dishonestly skirted paying. These patients included those who did not disclose that they could not pay prior to receiving health care services or ignored their agreements. Sentiments of anger toward particular patients ran strong for one who made an unsuccessful attempt to collect a payment through a collection agency. He claimed that he was angry because the patient had lied. Another health care organization official claimed that two unpaid accounts were plaguing her. A clinician who stated that none of his patients had lied to skirt paying him, claimed that doing so would have been embarrassing in a small society such as Martha’s Vineyard’s. However, other clinicians of his specialty had stated that they had delinquent accounts.

The large percentage of study participants who stated they had been indebted to health care organizations was surprising. Table 18 shows that of 112 HCC study participants, 38 (33.9 percent) had been indebted to a Martha’s Vineyard or a mainland health care organization (most often MVH). This did not include the eight study participants who claimed they had paid their bills one or two months late because they overlooked the bills, they were away, the bill was being disputed or the bill had taken long to be forwarded to a new address. It did not include 14 study participants who claimed they received their bills in error. Sources of such errors included medical coding

errors, a mistaken claim that medical equipment had not been returned to its lender, and an insurer’s mistaken denial of a payment.

Table 18. Percentage of those who claimed they had past due billing in response to “Have you or a member of your household ever had a past due health care bill from MV or off-Island health care provider?” n=112		
Past due billing	Responses	
	No	Yes
Percent	66.1	33.9

Theresa A. Sullivan, Elizabeth Warren, and Jay Lawrence Westbrook (1989) found that, compared with other debtors, those 1,500 cases with medical debts in ten districts they studied were significantly more apt to be taken to court. They also found that collection specialists claimed that physicians tended to quickly refer their unpaid bills to lawyers or collection agencies (Sullivan, Warren, and Westbrook 2000:154). Kovac’s (1991:710) study in Tennessee found that the medical providers that she studied collected their accounts aggressively (Sullivan, Warren, and Westbrook 2000:154):

Forty-one of the 197 cases (21 percent) reporting medical debt also reported lawsuits to collect that debt. Medical creditors were by far the most aggressive in their collection efforts. At least 14 of these lawsuits had resulted in attempts at garnishment; one bank account and two houses had been attached to satisfy medical bills. It should come as no surprise that the debtors filed bankruptcy petitions almost immediately after the attachments (Kovac 1991:710).

Martha’s Vineyard and some mainland health care providers had implemented heavy-handed methods to collect payments. Here, heavy-handed methods are lawsuits and referrals of delinquent patient accounts to a collection agency. Vineyard health care organizations used such methods on 10.5 percent of HCC study participants overall. Of the 38 HCC study participants who claimed they currently or previously had past due billings, health care organizations used such approaches for 14 (36.8 percent). An MVH

official claimed that MVH was referring three to five percent of its patients to a collection agency and suing approximately 25 to 30 percent of patients who ignored collection agency attempts. It is likely that differences in the percentages that the MVH official provided and those found here stem largely from that this study included data about health care organizations besides MVH (shown in Table 19). Also, some of the methods used to solicit interviews may have produced higher percentages. Selecting Vineyarders who expressed positive or negative sentiments toward Vineyard health care services likely precluded more neutral views being expressed (excluding study participants obtained by cold telephone calls).

Table 19. Heavy-handed actions taken against HCCs who have had past due billings in response to “What methods did health care providers use to get payments?” n=38 compared with data provided by MVH official				
Responses by	Percent			
	Collection Agency	Litigation	Both	Neither
Study participant	21.1	13.2	2.6	63.2
MVH	3.0 to 5.0	≈1	≈1	**
**=Data not provided; ≈=approximately				

Some HCCs whose accounts were delinquent claimed that MVH allowed little time before contacting a collection agency. An MVH health care trustee claimed that MVH used an after “three strikes you’re out” policy, that is, after three bills went unpaid, MVH referred a patient’s account to a collection agency. A Vineyarder’s letters from collection agencies resulting from a single emergency department visit showed that MVH’s collection agency contacted the patient eight months and the MAG Physician Organization’s 6 ½ months after providing the services. Like the married couple Theresa A. Sullivan, Elizabeth Warren and Jay Lawrence Westbrook (2000:154-155) described, a

study participant claimed that, though she followed her payment plan according to the mutually agreed terms, MVH referred her account to a collection agency. The reason why is anyone's guess. Perhaps MVH officials became aware that this person received a large amount of money; MVH officials were trying to resolve a budget shortfall; the agreement was overlooked; MVH reneged or a bureaucrat erred.

Collection agencies tried to pressure Vineyarders into paying their debts. Such agencies sent letters that stated a credit bureau would be notified if the debt was not paid within a certain period of time. After the credit bureau was notified, one's credit rating would be tarnished and lending organizations would charge higher interest rates if that person had applied for a loan. This kind of punishment was irrelevant to those who did not plan to use lending organizations to borrow money. However, houses, business startups, and automobiles cost too much for most Vineyarders to purchase unless they were to borrow money. To avoid such high interest rates, some Vineyarders stated that they paid their delinquent accounts when they decided to make such a major purchase.

Two MVH health care administrators claimed that MVH sued those patients who did not contact MVH's financial counselor and ignored their bills. A high-ranking MVH health care professional claimed that if a patient did not take the initiative to contact MVH, then MVH had "no choice" (field notes) but to aggressively collect payments owed. Given the extremely high costs of hospital care, those who avoided contacting MVH may have been reacting normally to a debt they viewed as insurmountable. Like a majority of study participants who had claimed to have been ignoring their bills, a VHCAP professional claimed that she had encountered many who claimed they feared

contacting MVH to try to resolve their delinquent accounts. In a society where achieving wealth is a cultural goal (Merton 1968:193; Merton 1938:676), it could be difficult (as some study participants claimed), to admit failure to afford health care or health insurance. This was apparent also after it was noted that a Vineyarder had become insulted by one's recommendation of IHC for health care services. It appeared that she had believed (as likely did several others) that only poor and uninsured people used that clinic. She appeared indignant while she responded, "I have health insurance."

A high-ranking MVH administrator asserted that suing a patient for payment was ethical if he knew that patient had the means to pay. Martha's Vineyard Hospital held court hearings one afternoon a month in the Dukes County courthouse. This administrator claimed that it was necessary for MVH to litigate against those whose accounts were outstanding to prevent people from taking advantage of MVH. An MVH health care administrator claimed that using heavy-handed collection approaches on undeserving patients helped to enable some truly needy Vineyarders, including MVH minimum wage employees,³² to gain access to health care services. Ironically, this administrator used MVH's lower echelon employees' poverty wages to legitimate MVH officials dunning people for money owed and thereby, potentially impoverishing them or driving them to bankruptcy.

Vineyarders who underwent MVH's aggressive collection methods buttressed the Dennis Andrulis et al. (2003:3) and Joel S. Weissman (2005) findings (Pryor et al. 2003:2; Mahar 2006:208-210) and Weissman, Dryfoos, and London (1999:164) suggestion that those indebted to a hospital avoided using that hospital. To be sure, such

avoidance was more difficult on an island with only one hospital. Others claimed they avoided health care services either because they did not believe in using services that they could not afford or they feared receiving services if they did not know the costs.

Martha's Vineyard Hospital patients could have received "financial counseling" before treatment only if the treatment was a planned elective treatment. An MVH administrator claimed that it was unethical to give patients information that could lead them to consider their costs while making health care decisions. This may suggest they were promoting access to health care because patients would have been able to obtain all the health care that his physician ordered without consideration of the costs. However, this policy likely silenced patients who expressed their payment concerns. Also it likely promoted a higher use (and perhaps overuse) of expensive diagnostic tests and treatments while it enabled MVH to maximally profit from the personnel and technology in which it had invested. A maximized use of health care services may have benefitted MVH even if a patient could not afford such services. Some such patients may have paid MVH through programs that MVH or VHCAP counselors recommended. Also, MVH could profit if a patient paid at least part of what was owed.

Health Care Policies Diminish and Divide Communities

Health care policies such as those discussed above, deprived too many Vineyarders of health care services. They potentially deprived them also of their communities. Those who filed for bankruptcy may have been economically forced to relocate. "Medical bankruptcies" are those filed because of large medical debts or

illnesses that led to lost income (Himmelstein et al. 2009:1). One who declares bankruptcy³³ files:

a petition in a federal court asking for protection from creditors via the bankruptcy laws. . . . The instant a debtor files for bankruptcy, the court assumes legal control of the debtor's assets and halts all collection efforts.

Shortly after the filing, a court-appointed trustee convenes a meeting to inventory the debtor's assets and debts and to determine which assets are exempt from seizure. States may regulate these exemptions, which often include work tools, clothes, Bibles, and some equity in a home (Himmelstein et al. 2005:W5-64).

Data were not found on Martha's Vineyard percentages. Sullivan, Warren, and Westbrook (1989) found that seven percent of US families filed bankruptcy in 1981 after experiencing medical debt or a loss of health insurance (Sullivan, Warren, and Westbrook 2000:155). Twenty years later, David U. Himmelstein et al.'s (2005:W5-63, 73 n. 12) study of a random sample of people in five districts in five US states (California, Illinois, Pennsylvania, Tennessee, and Texas) found that medical bills or illnesses led to close to half the personal bankruptcies filed (Himmelstein 2009:1). By 2007, this increased to 69 percent of debtors (Himmelstein et al. 2009:4).

A majority of the Americans in Himmelstein et al.'s (2009:1) 2007 study who filed for bankruptcy worked in middle class occupations. Those of the 2001 study worked in middle class or working class occupations (Himmelstein et al. 2005:W5-66). In both studies, a majority owned their homes and held advanced educational credentials or had at least some college education (Himmelstein et al. 2009:1; Himmelstein 2005:W5-66). Both the 2001 and 2007 studies found that slightly more than three-quarters (75.7 percent and 77.9 percent) of those whose medical bills led to personal

bankruptcies were insured when their illnesses began (Himmelstein et al. 2005:W5-63; Himmelstein et al. 2009:4).

Personal bankruptcies produced community instability, social network breakdowns and downward spirals. After people were economically forced out of their homes and communities, bankruptcies made it difficult to become reestablished in one's own or a similar community. After a bankruptcy, one's credit report was tarnished for ten years. Like those whose unpaid debts were reported to the credit bureau, those with tarnished credit reports of their bankruptcies were charged higher interest rates for home mortgages and higher rates for automobile insurance (Himmelstein et al. 2005:W5-63). The names of those who declared bankruptcy could have been published in a local newspaper or posted on the Internet. Vineyarders were "living in a fish bowl" hence such news could reach many without the use of these media. This could increase difficulties while searching for a job because employers may use applicants' credit ratings to assess their levels of reliability (Himmelstein et al. 2005:W5-63).

Such collections policies and high costs of insurance and health care led Vineyarders to worry. Some who held employer-sponsored insurance worried that had they lost their jobs, they would not have been able to afford to obtain health care given the high costs of health care and health insurance. Competition for scarce health care resources promoted community divisiveness on Martha's Vineyard. Brazilians were Martha's Vineyard's year-round immigrants who formed encapsulated communities of Brazilians. Vineyarders, including Brazilian immigrant Vineyarders, consistently stated that Brazilian immigrants had quickly learned (through their social networks) about the

processes of obtaining free health care. Some Vineyarders who had been denied public health care services claimed that the Brazilian immigrants who applied received such benefits often, because they had not declared their incomes. Some Vineyarders disparaged the VHCAP because they claimed it helped Brazilian citizens much and US citizens little, if at all. In 2004, the VHCAP chief Sarah Kuh claimed that of its 1,500 clients, approximately 600 to 700 (40.0 to 46.7 percent) were Brazilian (Burrell 2005:9). United States citizen Vineyarders' attitudes toward Martha's Vineyard's Brazilian immigrants varied. Their beliefs ranged from all Martha's Vineyard's Brazilians should be able to obtain health care regardless of ability to pay to undocumented immigrants should receive nothing for free and should be required to return to their homelands because they had broken US immigration laws. They broke such laws when they stayed in the US past their allowed stays or had furtively crossed the border.

Brazilian immigrants were disparaged by some Vineyarders also because they competed with US citizen Vineyarders for jobs while jobs were scarce.³⁴ Vineyarders did not necessarily recognize that some Brazilian immigrants migrated to escape harsh competitive relations and a lack of opportunities to generate sufficient incomes (Martes 2011:3, 17, 61, 62, 63; Margolis 1994:xvi, 3, 6). Such a lack of opportunities stemmed from US government and international trade agreements like the North American Free Trade Agreement (Lyons 2006:A-3). Such agreements produced conditions where manufacturing corporations had located south of the US border while a service economy dominated in the US. Global corporations usurped traditional local economies and displaced small family farming and other small business owners and employees (Lyons

2006:A-3) with factories that did not absorb all who were displaced. Hence, emigrating became necessary for survival (Lyons 2006:A-3, A-4).

Vineyarders complained rarely, if ever, about the Eastern European and Jamaican immigrants³⁵ who migrated each summer to Martha's Vineyard then left at summer's end.³⁶ These seasonal immigrants arrived to fill Martha's Vineyard business owners' demand for employees and departed once the demand decreased. These summer immigrants obtained temporary, non-immigrant, H-2B visas before coming to Martha's Vineyard (Christensen 2008). The US government provided H-2B visas to help fill the demand for laborers during seasonal spikes in demand for laborers (Christensen 2008). These immigrants did not use Martha's Vineyard's public welfare system. To receive an H-2 visa, one was required to obtain adequate health insurance before entering the US.

Several Vineyarders who could not afford health care avoided using health care services or tried to find a health care professional who would agree to payment terms that they could manage. Several HCCs, including those who had health insurance, stated that they feared they would need health care again given the high amounts they could be or had previously been required to pay for health care. Some became indebted after they received a large bill and learned that their health insurers or health care charities did not cover all of the services. Some study participants and other Vineyarders avoided physician consultations because either they could not afford a physician visit or they viewed a physician visit as useless because they lacked funds to carry out a physician's recommendations (Kuh 2001:15). While those few extremely wealthy and Vineyarders experienced no difficulties paying for health care and who had top-of-the-line insurance

plans, other insured study participants were reducing or skipping dosages to lengthen the time before refilling their prescriptions. That an MVH itinerant nurse was among them was surprising. Nursing students are taught to heavily proscribe changes to prescription drug dosages without a physician's approval.

Some Vineyarders received public health benefits. The few who bartered had received health care in exchange for landscaping or construction services. They had landscaped the grounds or built an addition to the physician's house. One claimed that his only recourse to health care was to consult his registered nurse (RN) neighbor who did not charge him for her recommendations.

Chapter Summary

This chapter argued that Vineyarders held different sets of value orientations (along some continuum of health care and business values) that were significant to their viewing those who were deserving and undeserving of health care regardless of ability to pay. First it discussed ways in which Vineyarders coped with health care challenges that were unique to islands such as Martha's Vineyard that relied on tourism and that did not have a bridge that connects to the mainland. Political technologies helped to promote little public discourse while problems that had been imported from the mainland, such as health care rationing, were carried out.

Health care was roughly divided into health care services for elites, for non-elites who could pay, and for those who could not pay. Some health care providers distinguished deserving and undeserving of health care according to ability to pay, by

personal traits such as motivation to work, and demographic characteristics such as citizenship. Health care organizations' actions suggested their varied sets of commitments to providing health care regardless of a patient's ability to pay. Most, if not all, Vineyard health care organizations provided free health care to at least some of their patients. Some health care organizations claimed that they provided health care for all who sought their services. However some, including some that made such a claim, pushed away Vineyarders who had not paid for their health care services. Using policies such as aggressive collection policies or requiring one to spend all of one's savings before qualifying for free health care motivated Vineyarders to avoid using health care services. Also, insurers harassed those who tried to use their health insurance benefits. This chapter discussed ways in which community intimacy mitigated some of these harsher aspects of the health care system. Chapter 3 argues that Martha's Vineyard health care services were structured to provide health care and to produce profits.

Chapter 3. Organization of Martha's Vineyard Health Care Providers

This chapter examines the constituents and organization of Martha's Vineyard health care providers that existed during this field research and the values that played a part in promoting them. The term "organization of health care" is defined here as the rigid hierarchy of dominance and subordination in which health care professionals were ordered, how health care tasks were divided across professions and across organizations, and some of the roles Martha's Vineyard health care professionals performed. This chapter discusses the values that led to the formal business networks described below that existed between Vineyard health care organizations, between these organizations and mainland health care organizations that provided health care to Vineyarders, and between the health care organizations and state and local governments.

This chapter argues that health care providers exhibited egoistic and collective utilitarian values while they formed their health care organizations, their health care networks, and their formal and informal policies for the inclusion within and exclusion of Vineyarders from health care services. Likewise, Vineyarders had accepted and rejected particular health care providers, within the limits posed by health care scarcities, by choosing or avoiding a kind of health care provider (e.g., mainstream, alternative, physician or nurse) or a particular health care organization or health care professional such as a physician with which one was not satisfied. First this chapter discusses the

stratification of Vineyard health care professionals and describes their order within their health care hierarchies then it introduces each (by occupational status).

Vineyard Health Care Professional Stratification

Like mainland health care professionals, Martha's Vineyard's were organized stratified according to their occupational statuses, their educational credentials, and stratified according to factors such as the amount of physical labor they perform and the levels of expertise required for the tasks they perform. The Vineyard health care professionals of interest here are HCTs, HCAs, and clinicians. Such professionals, like the Vineyarders who volunteered in the nonprofit organizations discussed in Chapter 1, were solidified both organically and mechanically (Durkheim 1997:60-61, 83-85; Coser 1997:xiv, xvi, xix). Members of each specialty carried out their occupational roles while they depended on members of other specialties to perform their specialized set of skills in their efforts to provide standardized health care. Health care organizations hired professionals in an effort to achieve organizational goals. Those who shared a profession (and HCTs) tended to be united through mechanical solidarity. Health care professionals shared values that were inculcated during their health care educations. Health care trustees often did not share occupational statuses but shared their elite statuses, elite social networks, and their beliefs in their health care organization's mission.

Health care trustees are philanthropists. After interviewing 99 New York City area wealthy donors, Ostrower (1995:3) claimed that philanthropy "plays a central and defining role in upper-class culture." Philanthropy marked elite status (Ostrower

1995:11) within both the organization and the society. Philanthropy provided the wealthy with avenues to network, social cohesion promotion (Ostrower 1995:6), and the ability to “fashion a separate cultural world” (Ostrower 1995:134) or as Newby (1980:259) put it, to form encapsulated communities. While performing their roles, the trustees of Ostrower’s (1995:136) study tended to associate only with highly ranked employees within the organizations. While mainland (Ostrower 1995:135) and Vineyard elites tended to associate with fellow elites, Vineyard elites and non-elites may interact at some community events that tended to attract Vineyarders of all economic statuses. While on Martha’s Vineyard, Vineyard elites tended to enjoy more relaxed, casual social encounters where they could enjoy events with a more diverse socioeconomic group.

The elite live in a social environment in which giving is a norm and philanthropy is characterized as an obligation for the worthy who hold a privileged position (Ostrower 1995:12). Health care trustees were elite philanthropists who donated their time, money, and ideas to their organizations (Ostrower 1995:5). Like mainland HCTs (Culbertson 2004:46), Martha’s Vineyard’s were prominent community members who sat atop their health care organizational hierarchies. Some HCTs also held high-ranking occupational positions within the health care organizations on whose boards they served. Health care trustees’ main responsibilities tended to be “clean” and highly valued. They were responsible for the direction of overall policy (*Vineyard Gazette* 2017b:12), the organization’s financial health, and the hiring of the organization’s CEOs (*Vineyard Gazette* 2017b:12; Kaplan 2006:44).

Boundaries that encapsulated elite communities were, “to a large extent, maintained by the simple necessity of having large sums of money in order to participate” (Ostrower 1995:134). On Martha’s Vineyard, such events included a cocktail reception with Senator Bob Dole for a suggested donation of \$400 per person (Trustees of Martha’s Vineyard Hospital 2000:3). Also, Vineyard health care organization trustees were required to donate money to their health care organizations. According to Smith (2000:130-131), US health care organizations informed its HCTs of the minimum amount they were required to “donate.” These minimum amounts ranged from \$10,000 to \$100,000 or more (Smith 2000:131). Trustees could measure one another’s standings by the amounts they donated and may have disparaged trustees who donated amounts other trustees viewed as inadequate (Ostrower 1995:14-16).

Some Martha’s Vineyard HCTs buttressed Smith (2000) and Francie Ostrower’s (1995) discussions about factors that may have motivated people to become HCTs. Such factors include board members who sought prestige (Ostrower 1995:8-9; study participant). Some study participants claimed that being a trustee provided opportunities to drop other trustees’ names and to be introduced to their social groups (Smith 2000:131). Perhaps on Martha’s Vineyard, an HCT position enabled the old rich to maintain their high social standings (Ostrower 1995:134) and the *parvenue* to demonstrate that they had arrived (Smith 2000:131). Philanthropy could be used as a means to assuage one’s guilt (Ostrower 1995:13), legitimate one’s wealth or to buttress the belief that one deserves one’s wealth (Gerth and Mills 1946:271; Ostrower 1995:14). Such elites may have desired “to give back something of the largess” (Ostrower 1995:13)

that they had gained (perhaps by exploiting communities). Like Ostrower's study participants, several Martha's Vineyard HCTs and other Vineyarders claimed that they donated time and money to Martha's Vineyard nonprofit organizations to "give back" to their communities.

Partners-employed MVH health care trustees made up 20 percent of MVH's board members (Sigelman 2007a:1). This 20 percent were highest on MVH's hierarchy if measured according to levels of wealth, prestige or power within MVH. After MVH was transferred to the Boston health care consortium Partners, trustees who were not Partners-employed continued to control MVH's day to day operations and the Partners-employed trustees had ultimate power—they controlled MVH's budget (Seccombe 2006b:9). In 2007, the Partners-employed trustees included two mainlanders who did not own property on Martha's Vineyard and two who did. These were Partners-owned MAG's president; MAG's senior vice president for surgical and anesthesia services and clinical business development (Seccombe 2006a:5); Vineyard summer home owners, MAG trustee and MAG's chief of surgery; and Partners's vice president and general counsel (Sigelman 2007a:9; Seccombe 2006a:5).

A nonprofit organization's executive director's (or CEO's) survival depended on maintaining good relations with board members. Health care trustees (as a group) had the power to fire an executive director. Hence, perhaps it is not surprising that three HCA study participants claimed an HCA's roles included working on board relationships or board development, recognizing HCTs' good work, or expressing gratitude for their support.

Occupational roles locate people in social space, set the stage for interactions, and mark social boundaries (Treiman 1977:1). As Table 13 (in Chapter 1) shows, a majority of Vineyard study participants (22.8 percent) identified their occupational communities or their occupational peers as their community. One's occupation "marks a person as 'someone to be reckoned with' or as one who can be safely ignored, one to whom deference is due or from whom deference can be expected" (Treiman 1977:1). Lower occupational positions tend to hold more stigmas (or taints) and less prestige compared with higher level ones. Those located in lower occupational health care positions tend to have more face-to-face contact with patients and tend to do more "dirty work." Everett C. Hughes (1951:295) defined "dirty work" as tasks that were "unpleasant . . . menial, and beneath one's dignity . . . something generally considered drudgery, that requires no skill."

The occupational ranks that require higher education and that remunerate status occupants well tend to be the least stigmatized or, as Mills, Drew, and Gassaway (2007:4-5) put it, "tainted." By Ashforth and Kreiner's (1999) criteria, while all jobs possess some level of taints, HCAs' work is tainted little. Their work is not degrading or disgusting (they do not handle dirty things). They use their minds, not their bodies. However, their level of taint rises if they work on behalf of stigmatized populations such as criminals, the mentally ill (McMurray 2012:140 citing Ashforth and Kreiner 1999, Ashforth et al. 2007, Stannard 1973, and McMahon 1998; Mills, Drew, and Gassaway 2007:4-5), the uninsured or those having certain diseases. As on the mainland (Roberts and Melnick 1989; Longnecker, Patton, and Dickler 2007; *New England Journal of*

Medicine Career Center 2011), Vineyard administrators' "clean" duties included aligning administrative and medical practice goals, coordinating clinical operations and inpatient and outpatient services, serving as a liaison, and taking part in risk management, public relations, professional liability, and information systems.

The boundaries that separated health care hierarchies were porous to greater or lesser degrees. While the nurse was subordinate to the physician, some emergency department nurses and visiting nurses claimed that physicians valued their input and tended to follow their suggestions. Others claimed that they experienced power struggles with physicians who would not listen to them. Also, physicians had the final say even if a nurse or therapist was more skilled at evaluating a patient's need for or at performing a procedure than the physician. This was the case for MVH physical therapists and nurses who held a Ph.D. in their fields. This did not necessarily benefit the patient. For example, a nurse stated that an MVH physician did not allow her to continue providing a simple and effective procedure because the physician preferred to use a more complicated procedure for which he could bill the patient.

Physicians were located on the highest rung of the clinician hierarchy. The literature shows that different levels of occupational status and prestige existed among physicians. The order of these levels depended on who was evaluating them. On one hand, people held different definitions of that which constituted prestige. On the other hand, they differentiated "prestige" according to culturally shared perceptions of levels of respect, admiration, or esteem (Norredam and Album 2007:656). A lack of uniformity of researchers' definitions of "prestige" is not surprising given the different methods used to

define prestige and the different populations used in studies of physician prestige (Norredam and Album 2007:659). Physician prestige had been measured according to levels of stigmas (as stated above), income, satisfaction with one's specialty, and admiration by other physicians or by the public.

Like social boundaries in general, people's definitions of prestige depended often not on the position itself, but on who is making the assessments. Rosoff and Leone (1991) stated that, unlike insiders, people outside the medical profession attributed the most prestige to those medical specialists they believed (wrongly) to be among the most highly paid (Glazer and Ruiz-Wibbelsmann 2011:314). Table 20 summarizes criteria that people used to define physician prestige. The criteria were not uniform. While physicians who did procedures often had higher levels of income than those of cognitive specialties, a large proportion of medical procedural specialists claimed they were dissatisfied with their specialties (Leigh et al. 2002:1582). Leigh et al. claimed that perhaps these procedural specialists' dissatisfaction increased in the late 1980s when managed care gained more traction and brought about a "considerable loss of income, autonomy, and job openings for procedural specialties" (Leigh et al. 2002:1582). Radiologists were one of the most highly paid that many chose as their specialties during their residencies. Yet medical professionals tended to evaluate radiology as holding a low or medium level of prestige (Glazer and Ruiz-Wibbelsmann 2011:311 citing Schwartzbaum, McGrath, and Rothman 1973, Shortell 1974, Sallee, Cooper, and Ravin 1989, Furnham 1986, Rosoff and Leone 1991, Hinze 1999, Kazerooni et al. 1997, Creed, Searle, and Rogers 2010, and Album and Westin 2008).

Table 20. Criteria that define physicians' prestige	
Higher prestige	Lower prestige
High job satisfaction	Low job satisfaction
High income	Low income
Narrow specialties	General practice
Use of technology	Less use of technology
More use of concrete skills	Less use of concrete skills, e.g., psychiatry
Use of procedures, e.g., surgery	More cognitive, e.g., psychiatry
More formal training	Less formal training
More effort to learn	Less effort to learn
Treat middle age, younger patients	Treat elderly
Treat upper body organs	Treat lower body organs
Action oriented	Talk oriented
Patients more high-ranking	Patients less high-ranking or stigmatized
Specialty attracts fewer women	Specialty attracts more women
Sources: Glazer and Ruiz-Wibbelsmann 2011:315, 311 citing Fuchs and Sox 2001 and Zafar 2007; Leigh et al. 2002:1582; Mills, Drew, and Gassaway 2007:4 citing Ashforth and Kreiner 1999; Norredam and Album 2007:657-659 citing Gjerberg 2001, Zhou 2005, Hinze 1999, and Wright et al. 2004.	

According to the criteria above, Vineyard physicians would have held less prestige than their mainland counterparts. Martha's Vineyard's population was too small for physicians to advance to higher occupational positions that would come with raises in income, to practice narrow specialties, to use cutting-edge technologies or to advance their educations on Martha's Vineyard. The transfer of MVH to Partners on the one hand brought physician prestige to MVH. This transfer of ownership integrated MVH "into the full spectrum of medical services at a world-class health care system" (Seccombe 2006a:1). On the other hand, perhaps this transfer produced a sense of relative impoverishment of prestige while working alongside visiting MAG physicians or while socializing with them in the wider society.

It is possible that Vineyard physicians surpassed their mainland counterparts in their job satisfaction. Compared with urban and suburban ones, physicians who relocated to Martha's Vineyard likely had shorter commutes (US Bureau of the Census 2000d) and more relaxed lifestyles in a place they viewed as pleasant and safe. Some derived satisfaction from practicing medicine in a place where patients and their physicians may have known each other in contexts outside the health care community. Vineyard physicians traded higher pay, lower cost of living and larger varieties of opportunities in which to advance their careers for living year-round in paradise. Trade-offs that Vineyard physicians made strongly suggest that they defined "the good life," not in a Benthamite sense (quantitatively, i.e., maximized wealth and status accoutrements), but in a Millsian (qualitative) sense.

Study participants did not provide data on the other criteria listed in Table 20. However, it seemed that a Vineyard psychiatrist did face a stigma by some. Whether his stigmatization had to do with his personality or his specialty is not certain. A health care professional study participant claimed that this psychiatrist strived for money, prestige and glory rather than for helping ordinary people with "real" problems. Also, one claimed that this psychiatrist refused to accept MassHealth, accepted only those patients who held high-paying insurances and only during business hours, and refused services to all emergency department patients except for those already on his patient roster. Conversely, his colleague stated that while he is by no means perfect, he was always there when in a jam and provided *pro bono* consultations if MVCS mental health counselors presented a good case.

Study participants did not discuss overt signs of devaluation of women physicians. However, some study participants suggested that women physicians were working harder and taking more of a load than some of the male physicians. Perhaps this was a sign of a devaluation of women physicians, but it is impossible to judge without knowing why they were working harder (by choice or external pressure) or what kinds of extra duties (clean or dirty) they were performing.

Being located highest within the clinician hierarchy provided physicians with much “insulation from observability” (Coser 1961:29, 35, 38; Merton 1957b:114). Those in higher occupational positions tended to hold more status insulation and tended to be superordinate to a larger number of subordinate status occupants than those in lower ones. Junior managers possessed less status insulation than senior managers and nurses less than physicians. Lower status occupants tended to be held accountable by more people in the organization. Junior managers or nurses were at more risk of being fired than senior managers or physicians. One way a physician’s status insulation was carried out is that, though nurses were required to obtain less education in pharmacology than a physician, the nurse was held responsible for notifying the physician if he provided an inappropriate medication order.³⁷ While this policy was an effective stopgap measure that benefitted patients, if a nurse had carried out a physician’s mistaken order, she likely would have been more apt to be sanctioned than the physician. Physicians’ statuses were insulated also because they often performed their roles outside the watchful collegial eye (Merton 1957a:77; Merton 1957b:115; Merton 1968:428; Coser 1961:33, 37).

Nursing made up the largest health care profession in the US (McWay 2008:19) and its members were occupationally diverse. Nurses provided health care in an effort to promote, maintain, and restore health and wellness and to prevent illness (McWay 2008:19). Physician extender nurses were advanced practice nurses (APNs) that held Master's degrees. As shown in Table 21, APNs were either nursing practitioners (NPs) or clinical nurse specialists (CNSs) (Center for Practice Improvement and Innovation 2010:2-3; Massachusetts Action Coalition 2014:3-6; American Academy of Physician Assistants 2006). Other physician extenders were PAs (distinguished from APNs in Table 21). Advanced practice nurses included midwife RNs who delivered neonates during uncomplicated births, nurses in solo or group nursing practices that treated patients with relatively routine ailments, and nurse administrators (American College of Nurse-Midwives 2012; Robertson 2004:433; Kenward 2007:1). Table 21 shows the degrees, examinations, and licensing necessary to becoming NPs, CNSs and PAs and the duties they tend to perform.

Table 21. Distinctions between Advanced Practice Nurse (Nursing Practitioner and Clinical Nurse Specialist) and Physician Assistant physician extenders			
Factor	Advanced practice nurse		Physician assistant
	Nursing practitioner	Clinical nurse specialist	
Education; degree	College nursing programs	College nursing programs	Physician or surgical assisting program
Exam	ANCC; NCC; AANPCP; or PNCB	A national certifying organization, e.g. NCC	NCCPA's National Certifying Exam
Licensing	State in which practicing	State in which practicing	License of MD by whom employed
Duties	Priv. practice, exam, diagnose, treat, prescribe, manage patients, obtain referrals	Adm services in acute care facilities	Exam, diagnose, treat, prescribe, manage patients
Supervisor	Physician	Nurse	Physician
Adm=administrative; ANCC=American Nurses Credentialing Center; AANPCP=American Academy of Nurse Practitioners Certification Program; Cert=Certification; Exam=examination; MD=physician; NCC=National Certification Corporation; NCCPA=National Commission on Certification of Physician Assistants; nsg=nursing; PNCB=Pediatric Nursing Certification Board; Priv.=Private. Source: Center for Practice Improvement and Innovation 2010:3, 5, 6; Massachusetts Action Coalition 2014:3-6; American Academy of Physician Assistants 2006; Massachusetts Medical Society 2015; Bayliss 2003-2011; Bushnell 2004; Kenward 2007:1-2.			

Robert McMurray (2012:126) viewed nurses as “subordinated adjuncts to the dominant” physicians. Nurse subordination to physicians was evident because physician extenders (Ferraro and Southerland 1989:193) and visiting nurses (Higinbotham 1983:1) tended to perform services that no longer interested physicians. Visiting nursing organizations freed physicians’ time, greatly reduced the number of physician house calls, and enabled physicians to spend more time providing billable services in their offices. Ferraro and Southerland (1989:192) claimed that both physicians and APNs tended to regard APN subordination to physicians as appropriate. While Martha’s Vineyard nurses may have critically evaluated the physicians with whom they worked, they tended to

accept their places in the health care hierarchy and that they were required to follow “doctors’ orders.” They were not required to follow such orders blindly. One of their professional responsibilities was to question physicians who ordered something in error or who failed to order something that should have been done.

Like physicians, all nurses (APNs, RNs, and licensed practical nurses (LPNs)) were required to be licensed by the state in which they practiced. Both APNs and undergraduate nurses could have improved their levels of prestige among colleagues through continuing education and nursing certifications for their specialties. Licensed Practical Nurses had less nursing education than RNs. For an LPN to have furthered her nursing education, she would have had to become a RN. Certified nursing assistants were located on the lowest rung of the nursing hierarchy. Hospitals and nursing homes employ CNAs and nurses. Visiting nurse agencies employ home health aides whose duties are similar to CNAs. Home health aides also do light housecleaning, laundry and meal preparation.

Nursing assistant work tended to be highly stigmatized. Management employees tended to devalue nursing assistants (Pfefferle and Weinberg 2008:952). Managers tended to expect CNAs to be servile (Höpfl 2012:13). Nursing assistants were paid little and handled body fluids. While some viewed nursing assistants’ work as degrading, others (including Vineyarders) viewed it as God’s work (Pfefferle and Weinberg 2008:956). Perhaps such a view was a defense mechanism to “transform the meaning of *dirt* and moderate the impact of social perceptions of dirtiness” (Mills, Drew, and Gassaway 2007:4 citing Ashforth and Kreiner 1999, italics in original). The fact that

nursing assistants' work entailed significant occupational risks also added to their stigma (Mills, Drew, and Gassaway 2007:4 citing Ashforth and Kreiner 1999). Lifting patients had led to a larger number of nursing assistants to have undergone workplace injuries than members of all other occupations (Zwerdling 2015). Nurses also were at significant risk for injuries (Zwerdling 2015). The CEO of the National Association of Geriatric Nursing Assistants claimed that nursing assistants' "work is demanding both emotionally and physically, yet many take a second job or put in overtime hours to make ends meet" (*Vineyard Gazette Health and Fitness Directory* 2002:8). Perhaps some sense of stigmatization was reduced for Martha's Vineyard nursing assistants who had known their patients before they were hospitalized or institutionalized in Windemere. Such CNAs were familiar with their patients in earlier roles such as a teacher, clergy member, store clerk or repair person. Study participants provided a few examples of Vineyarders performing dirty tasks while verbally insulting the patient. More often, they depicted such employees as performing such tasks kindly. Several claimed that they grew attached to their home health aides so much that they viewed them as members of their families.

The etymology of the term "patient" points toward the passive patient located at the bottom of the health care hierarchy. "Patient" is defined as a "long-suffering" (Merton 1976:71; Myers 1987:800) or as a "person *under* medical treatment" (MedicineNet.com 2016, italics added), who exercises restraint and endures patiently and quietly (Merton 1976:71; Myers 1987:800). A patient waits to receive, is receiving, or has received health care and exhibits calmness under strife, exercises anger slowly, and calms anger while maintaining compassion and graciousness (Myers 1987:800;

MedicineNet.com; Lockman Foundation 1998 citing *Holy Bible* (Numbers 14:18, Nehemiah 9:17, and Proverbs 15:18)). Such definitions point toward a noble patient who meets health care providers' expectations. Such a patient is compliant, subordinates himself to clinicians and shows few emotions, especially if such emotions would impede health care efficiency.

Different gradations of patients exist. As Arnold S. Relman (2001) noted, health care providers fiercely competed for paying patients (Mahar 2006:36). In a health care system designed to generate maximum profit, the best patient is a good investment, "a commodity, a product on an assembly line" (Grossinger 1995:55). By this criterion, a patient's value is the monetary value of billable services he receives. Hence:

if a sick person's insurance profile does not match the disease prognosis, i.e., does not guarantee that there will be money available to pay for the full treatment, bureaucrats are advised if at all possible not even to admit the patient (Grossinger 1995:55).

Like in mainland health care organizations, the Vineyard patient tended to be at the bottommost rung of the health care hierarchy. Health care professionals exerted much control over patients. Patients were required to follow health care organization rules. Health care professionals acted on behalf of the patient (real or imagined) while the patient was expected to be a passive recipient (Lidz, Fischer, and Arnold 1992:71, 76). Claims that a health care organization provided patient-centered care may have been contradicted by its actions. The discontinuation of the Planetree model suggested that MVH power brokers were committed little to this model of health care. Rather, it suggests that they were committed to it as a means to generate donations. Nonetheless, as

Chapter 2 discussed, Martha's Vineyard health care professionals often accommodated their patients beyond the duties described in their job descriptions, especially if they liked the patient. The section that follows outlines many of the Martha's Vineyard health care organizations that the above status occupants populate.

Nonprofit and For-profit Martha's Vineyard Health Care Providers

Nonprofit organizations (shown in Table 22) made up 13 percent of Martha's Vineyard's 2011 gross domestic product (GDP) (Martha's Vineyard Donors Collaborative 2011). The "gross domestic product" is the total value of everything produced by all individuals and companies in a particular region (Amadeo 2017). This large percentage was due in part to Martha's Vineyard's geographic isolation that limited Martha's Vineyard nonprofit organizations from sharing services with mainland nonprofit organizations (Martha's Vineyard Donors Collaborative 2011).

A majority of Vineyard clinicians stated that they practiced their health care occupations as a means to live on Martha's Vineyard as opposed to filling a need on Martha's Vineyard. This is pronounced most strongly when noting that physician specialists are more widely distributed across the towns while general physician practitioners are concentrated down-Island, especially in Oak Bluffs. The large concentration of physicians in Oak Bluffs is because MVH rents space to physicians.

Table 22. Year Martha's Vineyard health care organizations opened, their tax statuses and their purposes			
HCO	Year opened	Tax status	Purpose
MVH	1922	NP	Emergency and urgent care; treat/admit patients with life-threatening emergencies; swing beds
VNS	1965	NP	Post-hospital, rehabilitation, and chronic care
VNA	1984	NP	Post-hospital, rehabilitation, and chronic care
EMT	1976	NP	Ambulance services, basic life saving
Paramedic EMT	2005	NP	Ambulance services, advanced life saving
FPMV	1978	NP	Reproductive health care and family planning services
Hospice	1982	NP	End of life palliative care; spiritual and grief counseling
WTHS	1987	NP	Primary care for Martha's Vineyard's Wampanoag
Windemere	1994	NP	MVH-owned nursing home
IHC	2004	NP	A rural clinic
Physician practices	1673	fp	Primary and later, specialist care
Concierge practice	2006	fp	Primary care, hospital care oversight, preventative care for patients who pay annual membership fee
VCM	2003	fp	Chiropractor, acupuncture, massage, craniosacral therapy and aquatic physical therapy
<p>EMT=emergency medical technician (ambulance); fp=for-profit; FPMV=Family Planning of Martha's Vineyard; HCO=health care organization; Hospice=Hospice of Martha's Vineyard; IHC=Island Health Care; MVH=Martha's Vineyard Hospital; NP=nonprofit; VCM=Vineyard Complementary Medicine; VNA=Visiting Nursing Association; VNS=Visiting Nursing Services; WTHS=Wampanoag Tribal Health Services</p> <p>Sources: Banks 1966:495; Brennan 2001:1; Hefler 2008:9; Houghton 2011:19; Locke 2003d:2; Lovewell 2005:3; Manning 2010; Martha's Vineyard Community Services 2006; Rappaport 2008b:3; Strauss 2009/2010:52;. Vineyard Magazine 1924:7; Windemere 2000:8.</p>			

Table 23 shows health care services Vineyard health care organizations and MAG provided and Table 24 shows the distribution of some kinds of Vineyard health care professionals.

Table 23. Kinds of health care services Martha's Vineyard mainstream health care organizations provided								
Kinds of services provided	Hospital		W	Home care		Hospice	Clinic	
	MAG	MVH		VNA	VNS		IHC	FP
Most specialties/sub-specialties; research, teaching	■							
Acute, intensive, emergency, in/out pt care; surgery, radiology, RD, rehab.		■						
LT, LT transitional, skilled nursing, and intermediate nursing care, assisted living			■					
Mental health counseling, blood pressure clinic					■			
Grief counseling						■		
Urgent, routine and adult primary care; promotes wellness, prevention, self-care							■	
Physical examinations; gynecological services; pregnancy diagnosis, counseling								■
Home health care				■	■	■		
Homemaker services				■	■			
Primary care		■					■	
Diagnostic services	■	■					■	■
Obstetrics		■					■	
Substance abuse services		■			■			
Laboratory services		■					■	■
Physical/occupational/speech therapy		■	■	■				
Respiratory therapy		■		■				
Pain management			■	■	■	■		
Wound care			■	■	■			
Infusion therapy		■	■	■				
Social work services	■	■	■	■	■	■		

HIV=human immunodeficiency virus; FP=Family Planning of Martha's Vineyard; H=Hospice of MV; IHC=Island Health Care; LT=long term; MAG=Massachusetts General Hospital; MV=Martha's Vineyard; MVCS=MV Community Services, MVH=MV Hospital; pt=patient; RD=renal dialysis; rehab=rehabilitation; STD=sexually transmitted disease; VNA=Vineyard Nursing Association; W=Windemere Nursing and Rehabilitation Center; MW=midwifery

Like mainstream medical practitioners, those practicing alternative medicine were distributed unevenly across Vineyard towns. Vineyard alternative health care

practitioners included acupuncturists who performed, that which Vineyard acupuncturist Nancy Gilfooy described as “the insertion of extremely thin needles through the skin, to various depths at strategic points on the body” (Strauss 2009/2010:53). According to the World Health Organization, acupuncture could be used to help approximately 25 diseases, conditions, and symptoms (Strauss 2009/2010:53). Naturopathic physicians provided chronic disease management and prevention services and advised patients about herbal treatments, lifestyle, and nutrition through methods such as homeopathy and manipulative therapy (Tippens, Oberg, and Bradley 2012:259; Baer et al. 2012:247). Others included naturopaths, lymph drainage therapists, craniosacral therapists, therapeutic touch, and reiki practitioners. Lymph drainage therapists used “gentle manual maneuvers” (Upledger Institute 1996) to promote optimum lymph and other body fluid movement (Chikly 2001) to reduce edema, regenerate tissue, stimulate immune function, detoxify the body; and mitigate chronic fatigue, chronic pain, fibromyalgia, sleeping difficulties, and depression (Upledger Institute 1996). Craniosacral therapists used light touch to stimulate the body’s healing mechanisms in their efforts to mitigate central nervous system stressors; to resolve headaches, neck and back pain, chronic fatigue, scoliosis, and learning disabilities; and to improve function after brain and spinal cord injuries (Upledger Institute 1991). Therapeutic touch practitioners moved their hands to various locations above the patient’s body to manipulate the patient’s ‘life energy field’ or aura in an effort to free energy and to promote healing, balance, harmony, and proper alignment (Carroll 2007). Reiki practitioners transmitted energy from their palms in and around the patient’s body to stimulate healing, well-being, and relaxation (Strauss

2009/2010:53-54). The relatively large numbers of massage therapists in West Tisbury are employed by Vineyard Complementary Medicine (located in West Tisbury).

Table 24. Locations of Vineyard health care organizations						
Organization	Number located in each town					
	Edgartown	Oak Bluffs	Tisbury	W Tisbury	Chilmark	Aquinnah
MVH		1				
IHC	1					
FPMV			1			
Physician (GP)	1 day/wk	8	3			1 day/mo
Physician (Spec)	2	9	5	2	1	
Psych (not MD)		2	1	3	1	
VCM				1		
Naturopathic			1			
Acupuncture			5	2		
Massage	1	1	5	5	0	0
VNA (office)			1			
MVCS (office)		1				
Hospice (office)		1				

FP=Family Planning of Martha's Vineyard; GP=General Practitioner; Hospice=Hospice of MV; IHC=Island Health Care; MD=Medical Doctor; MV=Martha's Vineyard; MVCS=MV Community Services, MVH=MV Hospital; Psych=psychologists or psychotherapists; VNA=Vineyard Nursing Association; W=West; MW=midwifery

Health care was stratified on Martha's Vineyard. As stated in Chapter 2, those who could enroll in a concierge medical practice, also referred to as a "boutique medical practice" (Rylko-Bauer and Farmer 2002:485) were wealthy Vineyarders. Enrollees received easily accessible, more effective primary general or family medical physician services in exchange for an annual fee (shown in Table 17 in Chapter 2). Concierge medical practices provided same day medical appointments, longer office visits than non-concierge physicians, impromptu physician house calls and close physician oversight (during office visits and while following patients during emergency department visits or

hospital admissions) (Rylko-Bauer and Farmer 2002:485; Knope 2008:15; Hefler 2008:12). Martha's Vineyard concierge physicians facilitated their patients' health care with mainland physicians, coordinated follow up care mainland physicians recommend after the patients returned to Martha's Vineyard, and like MVH, provided information about diseases endemic to Martha's Vineyard (such as tick-vector diseases and tularemia). Concierge medicine enabled physicians to be unimpeded by insurers. Such medicine was likely similar to that which led them to become physicians.

Unlike medical practices for the elite, Wampanoag Tribal Health Services (WTHS) provided health care for all Wampanoag whether rich or poor. Wampanoag Tribal Health Services could be viewed as all-inclusive (all Wampanoag). On the other hand, it could be viewed as highly exclusive (of everyone but the Wampanoag). Wampanoag Tribe members often said that they felt protected by the tribe because it supported Wampanoag families and provided them free access to primary health care. The Wampanoag Tribe's having gained federal recognition in 1987 enabled the tribe to establish WTHS and to apply for federal, state and local funds to pay for tribe members' primary health care services (Manning 2010). Wampanoag Tribal Health Services's physician (available two days a month) and a full-time nurse (Fein 2007:12) provided health care, community health outreach, injury prevention, and human services (child welfare, social work, and elder services). The uninsured were not required to pay for WTHS services and the insured were not required to pay anything in addition to that which their insurers paid. Some Wampanoag stated that they believed that it is a tribal member's duty to hold health insurance if possible. They held the belief that doing so

freed more resources to use toward those in greater need. Thereby, they held the individual responsible on behalf of the tribe.

Wampanoag Tribal Health Services was the only Martha's Vineyard health care organization in which HCCs were included or excluded on the basis of their ethnicities. To qualify for the use of the WTHS, one must have been Wampanoag as determined by genetic testing or by the 1870 census (Pease 1871) that showed one descended from a Wampanoag (Manning 2010; Dresser 2011:151). Many tribal members who qualified for WTHS were of mixed blood. According to the 2000 census, there were 256 Native Americans (or Alaska Natives) (1.7 percent of Dukes County's population) who claimed one race (US Bureau of the Census 2000a). In 2010, that population was reduced to 183 (1.1 percent of the population) (US Bureau of the Census 2010). That population (Native American or Alaska Native "Race alone or in combination with one or more other races") grew from 406 to 472 or from 2.7 to 2.9 percent of Dukes County's population (US Bureau of the Census 2000a; US Bureau of the Census 2010).

The existence of WTHS strongly suggested that the federal government was committed to improving access to primary health care services for federally recognized tribes. Perhaps the federal government's commitment was a result of a collective conscience brought about by its historic role in the Native American loss of land, poverty, discrimination, and unprovoked wars against them (Weinstein 1994:xiii; McMullen 1994:129, 131). Like other Vineyarders, a Wampanoag who did not have the means to pay could find it difficult to access medical specialist services. The WTHS determined

for whom, on a case by case basis, it would allocate its limited funds to cover the costs of specialist care.

Visiting nurses were introduced to Martha's Vineyard in such a way that enabled physicians to maintain their dominance. When the American Red Cross set up Martha's Vineyard's first visiting nursing program in 1921 (*Vineyard Gazette* 1921:1), a necessary condition was that "The work of the nurse will in no way trespass upon the field and functions of the physicians" (*Vineyard Gazette* 1921:1). About 60 years after the first visiting nurse organization was established on the Island, factions within the Visiting Nursing Services (VNS) nursing community led more than half of VNS's nurses to leave MVCS and form Home Health Care Services of Martha's Vineyard (whose name changed to VNA) (Locke 2003c:12). Vineyarders showed their support when they pledged \$200,000 in startup money toward this new visiting nurse organization (Locke 2003c:1, 12). The nurses who left were alienated by administrators who changed VNS's system of budget allocations. Before the new system, budget allocations were made on the basis of the revenues a department produced. After this change, nurses argued that the reduction of funding for the VNS program was unfair because the VNS had brought a significantly larger portion of funds to the VNS than the portion of the budget that was allocated to them (Locke 2003c:1).

Enabling elders to continue living on Martha's Vineyard was significant to Vineyard communities. Nursing homes (*Vineyard Gazette* 1970a:1; *Vineyard Gazette* 1971: 1, 3) and programs, such as Vineyard Village at Home (Shea 2011:23; Vineyard Village at Home 2008), visiting nurses, and hospices were integral to elderly Vineyarders

who desired to stay on Martha's Vineyard. The sentiment that nursing home care on Martha's Vineyard is extremely important became poignantly clear in May 1970 after the Public Health and Public Safety Departments ordered Vineyard Haven Nursing Home to close because it did not rectify fire and other safety problems (*Vineyard Gazette* 1970a:5; *Vineyard Gazette* 1970c:4; *Vineyard Gazette* 1970b:7). Sadly, its patients had no place on Martha's Vineyard to go, hence they were forced to migrate to Cape Cod, Roxbury, and Framingham nursing homes (*Vineyard Gazette* 1970a:1, 5; *Vineyard Gazette* 1970c:4; *Vineyard Gazette* 1970d:8). By September of that year, MVH enabled some in need of long term care to stay on Martha's Vineyard when it converted eight of its medical-surgical beds into long term care beds (*Vineyard Gazette* 1971:1, 3). Martha's Vineyard Hospital's board chairman claimed that part of his motivation to include a 40-bed long term wing in the new (1974) hospital building was that Medicare limited the number of days it paid for a hospital stay. However, these limits were not applicable to a nursing home stay (*Vineyard Gazette* 1970d:8).

Four years later, expected long term care wing profits did not materialize. MVH trustees voted unanimously to hold Martha's Vineyard's long term patients hostage. The "ransoms" would have been tax subsidies for MVH's long term care unit to the tune of \$200,000 annually (to eliminate its operating deficit) (Caldwell 1978:1). If paid, Vineyarders could have avoided, as Vineyard physician at that time, Charles T. Claydon claimed, "From a medical point of view we are sending people [off-Island] to their death" (Caldwell 1978:1, brackets added). A university of Michigan study found that many nursing home patients who relocated to another nursing home died soon afterwards

(Golding 1978:8). Trustees threatened the public in the *Vineyard Gazette* with MVH's plan to abdicate MVH's responsibility for its nursing home patients. Martha's Vineyard Hospital trustee Thomas L. Frankenberg stated that it was up to the community to prevent the nursing home from kicking patients out. He stated:

In a nutshell, we are saying to the Island community: if you need and want long-term service it's your responsibility . . . The hospital represents the community. It is a community problem. The community of Martha's Vineyard cannot turn its back on its old people (Caldwell 1978:1).

Frankenberg contradicted himself in his last sentence where he separates MVH from the community MVH purportedly represents.

In 1994, MVH built Windemere (Martha's Vineyard's largest nursing home ever) in a failed effort to promote MVH financially (Gay 1995:1, 16). While Vineyarders were trying to raise funds for a nursing home, the guarantor of MVH's mortgage (the Department of Health and Human Services) would not approve a \$7.9 million bond issue needed to build it unless MVH met conditions that MVH administrators claimed were impossible to meet (Orr 1992:1). A banking community enabled MVH to overcome this difficulty and build Windemere. Dukes County Savings Bank (DCSB) purchased the mortgage and provided MVH reasonable terms for paying it (Orr 1992:1) and thereby "rescued the Martha's Vineyard Hospital's long term facility" (Orr 1992:1). According to the *Vineyard Gazette* (1992:14) editor:

Dukes County Savings has . . . done much more than help the hospital clear a financial hurdle. This bank has reminded us that institutions, like individuals, have a citizenship and a responsibility to community that must never be forgotten in the pursuit of profits. The Dukes County Savings Bank has reminded us that to invest in the quality of Island life is the wisest and best investment of all.

While this continued to be a valuable investment to Martha's Vineyard communities, DCSB took a significant financial loss. Dukes County Savings Bank was among MVH's creditors that suffered significant losses when, as discussed earlier, MVH declared bankruptcy.

A study participant's depiction of Windemere's criteria for obtaining a nursing home bed suggested that Windemere was profit-oriented. Once a bed was available, a significant criterion to Windemere's acceptance of a patient is how much money that patient could produce for Windemere. The chances of being accepted into Windemere were significantly increased if the patient could pay, out of pocket, for a minimum of six months. At the time of my field research, depending on the level of services needed, the cost for six months was an amount out of reach for many Vineyarders. It ranged from \$41,245 to \$56,757 for a shared room and \$46,902 to \$66,247 for a private room (Windemere [2007]). Possessing a good long term care insurance policy improved one's chances of being accepted into Windemere. However, it was likely a small percentage of Vineyarders possessed long term care insurance. In 2008, Richard W. Johnson and Janice S. Park (2011) found that 12.4 percent of elderly Americans and 8.8 percent of Americans aged 55 to 64 held long term care insurance from private insurers.

Windemere sometimes rejected a Martha's Vineyard over a mainland resident if it could extract more money from that mainland patient.³⁸ It was not mere guess work to determine how much they could have extracted from applicants. The application to Windemere required submitting documents that validated a detailed account of one's income, savings, and other assets. Windemere also took into account a family members'

willingness to institutionalize the patient. This was likely because such family members would have been less apt to disrupt Windemere's routines, to complain, to sue, or to speak disparagingly about Windemere. A physician's validation that the patient needed institutionalized care at a skilled nursing facility was necessary for Windemere to receive Medicare reimbursements. Medicare reimbursed the first 100 days for patients who qualified³⁹ (Centers for Medicare and Medicaid Services 2015:7, 17).

Health Care Organization Networks

Martha's Vineyard's health care organizations could be viewed as structured according to Andrew Wellever's network model. Such networks provided significant potentials for forming and maintaining communities. Wellever (2004:226) defines "network" as "a set of nodes and the relations that occur among them." Other terms for networks are alliances, associations, coalitions, committees, communities, consortiums, and federations. The "form" is "the structure of relationships" and the "content" of a network "is what flows between and among nodes, such as information or services" (Wellever 2004:226). Martha's Vineyard organizations formed business networks with Martha's Vineyard and mainland Massachusetts health care organizations. These networks were to the benefit of each health care organization. Business networks enabled health care organizations "to either secure inputs or dispose of outputs" (Wellever 2004:227 citing Pointer, Begun, and Luke 1988). These business networks "occur when members form a chain of production in which the output of one organization becomes the input for another" (Wellever 2004:227).

Before MVH owned Windemere, MVH and Windemere networks were vertical according to Wellever's definition. Inputs and outputs could be two way as were networks (referrals) between MVH and Windemere and MVH and Martha's Vineyard's visiting nursing organizations. Using Wellever's model, MVH became Windemere's hub after its ownership was transferred to MVH. Martha's Vineyard Hospital was affiliated with Windemere since 1998 when MVH was made the sole member of Windemere Nursing Rehabilitation, Inc. (a new company that MVH created) (Wells 1998a:1). Windemere Nursing Rehabilitation, Inc. owned Windemere and had its own board of directors (Wells 1998a:1). Although Windemere was producing a large deficit each year, MVH purchased it in 2000 (for \$1.5 million) to prevent it from closing and to enable it to emerge from bankruptcy (Wells 2000a:1).

While Martha's Vineyard communities continued to benefit from the transfer of Windemere to MVH, MVH benefitted significantly from owning Windemere. Keeping Windemere afloat provided MVH a steady stream of nursing home patients who became acutely ill. A significant factor in the belief that Windemere would support MVH financially was that Medicare did not reimburse hospitals for long term care for elderly patients in acute hospital beds (Platt 1991:1B; Gay 1995:16). As in MVH's long term wing in 1974 (Platt 1991:1B), the long term financial stability that Windemere was expected to provide for MVH did not materialize (Gay 1995:16). As Wellever might have put it, organizations such as Windemere and visiting nurse organization outputs (patients who became acutely ill) were inputs for MVH. Conversely, MVH's patient outputs that became Windemere and home care organization inputs were those who

needed rehabilitation, institutional or home care. Like nursing homes (*Vineyard Gazette* 1946:1), visiting nurses prevented rehabilitation and long term care patients from filling beds that otherwise would have been filled by more profitable acute care patients. While such networking promoted profiting, it also helped to enable Vineyarders to stay in or closer to their communities. Hospice also provided MVH with outputs for chronic care terminally ill patients who were at the end of their life cycles (Wolfson 2004:4). Its mission was “to meet the unique physical, emotional and spiritual needs of all who are facing advanced illness and loss, and to give them hope, comfort and compassion” (Wolfson 2004:4).

Before Partners bought MVH, MVH formalized its business networks with two Partners hospitals in Boston, MAG and Brigham and Women’s Hospital (Guzman 1998:1). These networks “shortened Vineyarders’ distances” from physicians of some specialities (e.g., oncology and pulmonology) who visited Martha’s Vineyard to provide their services (Guzman 1998:1). These networks guaranteed hospital beds to Vineyarders airlifted to MAG or Brigham and Women’s Hospital (Guzman 1998:9). Such networks facilitated ease of MVH patients referred to these hospitals for procedures that included diagnostic tests (such as angiograms and cardiac catheterization), cardiothoracic surgery, and neurosurgery (Thompson 2001:17).

Medical and communication technology also shortened the distances between Martha’s Vineyard and mainland clinicians and patients. Communication networks reduced Martha’s Vineyard’s isolation significantly for neurology patients in 1998 when MVH entered into a contractual arrangement with MAG. With this agreement, MVH

sent radiological images taken at MVH to MAG⁴⁰ through Integrated Services Digital Network lines (Martha's Vineyard Hospital 2001:3; Walsh 2002:2; Hirshberg 2001:8; *Vineyard Gazette* 2000b:6). Thereby, a neurologist located in Boston could evaluate a patient located at MVH (Martha's Vineyard Hospital 2001:3; *Vineyard Gazette* 2000b:6; Guzman 1998:1). After MVH's ownership was transferred to Partners, the structure of the MVH and Partners network changed significantly.

Horizontal integration enabled “the transcendence of consolidated, multiple institutional, regional, or national chains over single, freestanding community agencies” (Estes, Swan, and Associates 1993:9). Horizontal integration is the merging of two or more companies that produce or sell the same kinds of products or services. Under a star network model, a larger, more central organization linked with several rural (Wellever 2004:228), and in the case of Partners, also with suburban Boston health care providers. Such linkages were not systems because joint finances would be entailed under a system (Wellever 2004:228). According to this criterion, Partners would not have been viewed as a system because it did not merge most of its clinical operations (Allen and Bombardieri 2008; *Boston Globe* 2008). Star networks were advantageous because they were mutually beneficial and they did not entail a large financial investment. For horizontal networks to work, reciprocity and trust, as opposed to a high degree of competition, were necessary.

Martha's Vineyard Hospital became part of Partners's horizontal “star network” or “hub-and-spoke model” (Wellever 2004:228) when it shifted its ownership to Partners in 2006 (Seccombe 2006a:1). Since then, MAG was MVH's sole corporate member

(Carroll-Bergman 2010). After MVH's ownership was transferred to Partners, MVH could modernize and Vineyarders could access a larger variety of secondary health care services on Martha's Vineyard.

Vertically formed networks occurred "between organizations operating in different segments of the same industry" (Wellever 2004:227 citing Pointer, Begun, and Luke 1988). Vertical networking enabled diverse member organizations to form relations that were more cooperative and less competitive. A business vertical network (referred to as a business network) is one kind of vertically integrated rural health networks. As with horizontal networks, members of a vertical business network made efforts to improve each member's financial position (Wellever 2004:228).

Vineyarders with substance abuse issues might have traveled through vertical networks at MVH's emergency department. Martha's Vineyard Hospital outputs to those stigmatized health care specialties such as mainland detoxification programs were becoming more difficult to procure especially for those with a second stigma (not possessing health insurance). According to Martha's Vineyard mental health care and other health care providers, there was a great need for mental health services on Martha's Vineyard. Nonetheless, the government had stigmatized those who used and who provided mental health care services when it significantly reduced their funding. Such cuts initiated facility closures. By 2010, 30 telephone calls might have been made before finding a detoxification bed for an MVH patient (McAllister 2010:10).

Martha's Vineyard Hospital's two substance abuse counselors shared 24-hour, on call duties (McAllister 2010:9). They provided consultations for MVH emergency

department patients who suffered complications from alcohol or narcotic drug ingestion or who requested mental health care. Martha's Vineyard Hospital referred these patients to MVCS's outpatient addiction counselors who, in turn, may have referred them to mainland detox programs (McAllister 2010:9, 10). These organizations provided MVH a way to dispose of these stigmatized outputs. Martha's Vineyard Community Services filled a niche in which physicians outside of psychiatry tended not to be comfortable (Crapanzano and Vath 2015:686; Welch et al. 2015:1014 citing Loeb et al. 2012). Also, MVH's substance abuse counselors and MVCS's mental health counselors were on call. This enabled MVH's one psychiatrist to avoid on call duties and to avoid providing services to such emergency room patients who might not have paid for services.

Networks that Helped Mitigate On-Island Geographic Barriers to Health Care

Some Martha's Vineyard locations presented added barriers to and difficulties in accessing health care. A drawbridge joined (or separated) one of two routes to MVH from Vineyard Haven. Aquinnah and Chappaquiddick were geographically isolated from MVH and other health care organizations. An Aquinnah study participant who did not own an automobile stated that it was difficult to find affordable child care. She stated that she could not take the bus to MVH with "my children hanging all over me." Martha's Vineyard paramedics shortened travel distances for patients traveling by ambulance. Paramedic emergency medical technicians (EMTs) enabled more kinds of interventions to be provided *en route* to MVH compared with intermediate or basic EMTs.

Chappaquiddick presented a challenge because the “Chappy” ferry did not run during late night and early morning hours. If the Chappy ferry was not running, a Chappaquiddick resident EMT began care before the ambulance arrived. Also, all Chappy firefighters were certified to perform cardiopulmonary resuscitation. The Chappaquiddick fire station housed emergency medical equipment such as defibrillators (to reverse cardiac arrest) and epi-pins (to reverse anaphylactic shock) (Chappaquiddick Island Association Welcoming Committee 2015:5). An ambulance was sent from another part of Edgartown if an ambulance was not parked on Chappaquiddick. A Chappy ferry operator was on-call every night to ensure a Vineyarder with a medical emergency could have been transferred at all times across the 527-foot waterway (Dunlop 2012) that separated Chappaquiddick from the rest of Edgartown.

When the draw bridge between the Vineyard Haven and Oak Bluffs waterfronts opened to allow sail boats to enter or leave the lagoon, traffic often backed up significantly. A telecommunications center⁴¹ operator shortened the distance (in time). It could notify an ambulance driver *en route* to the hospital if the drawbridge was raised so that it could take another route. It could notify the bridge operator to ask him to delay opening the bridge if an ambulance was *en route* to MVH.

Vineyarders’ isolation from tertiary care centers was mitigated by flight transport services. Some insurers covered all their beneficiaries’ medical emergency helicopter flights from Martha’s Vineyard because the Island was isolated from the mainland (Sigelman 2007c:36). MedFlight helped save a patient’s life, limb or sight (Tumin 2013:1). It flew critically ill patients who needed emergency air transportation to

mainland hospitals for health care services that went beyond MVH's capability (Tumin 2013:1).

The US government drove up the cost of flying Martha's Vineyard (and other) patients to mainland health care organizations in 2007 when it drove up demand for MedFlight services. Boston MedFlight and US Coast Guard officials signed a memorandum of agreement stating that the Coast Guard would be used "only for the most serious incidents and when there are no . . . alternative services available" (Sigelman 2007b:32). MedFlight transported Vineyarders only after they were evaluated at MVH. The policy of transporting all trauma patients to MVH before MedFlight is summoned was to provide services to that patient and ready the patient for the flight before that patient was airlifted. This benefitted MVH's bottom line while also benefitting patients (provided that the patient was better off with the services than without them).

Martha's Vineyard Community Health Networks

Martha's Vineyard's community advocates formed collectivities to mitigate some of the threats to Martha's Vineyard communities. These collectivities used either collectivistic or individualistic solutions to community issues. For example, land conservation organizations conserved land so that all Vineyarders could have access to it. Those who led efforts to promote access to adequate housing and health care helped one individual at a time and left many wanting.

Many Vineyarders recognized the US government's limitations in providing its citizens with an effective system of accessing health care. They often attributed such

limitations to “stakeholder mobilization” (Quadagno 2004:25, 39). “Stakeholder mobilization” occurred when stakeholder groups “mobilized politically against . . . government programs that might compete with private sector products or lead to government regulation of the market” (Quadagno 2004:28). Failure to provide an effective health care system had led Vineyarders to mobilize. Martha’s Vineyard community activists had formed collectivities in which they implemented egoistic utilitarian methods in their efforts to mitigate difficulties in accessing health care.

Vineyarders who formed collectivities that protected, promoted and maintained Martha’s Vineyard communities tended to be united by both mechanical solidarity and organic solidarity. Vineyard HCTs and others who supported Vineyard nonprofit organizations were united by that specific cause which members of their organizations advocated. They were also united by organic solidarity while they pooled their particular talents on behalf of their organizations and the people these organizations served. Such talents may have included bookkeeping, public relations, educating the public or “working in the trenches” toward the causes for which their organizations were formed.

Instead of forming business networks, they formed “community health networks.” Such networks are political networks that usually contained members from a single community or, as was the case on Martha’s Vineyard, a single county. Community health networks, like those on Martha’s Vineyard, tended to be concerned with investigating and monitoring health care organizations to identify problems and propose solutions. A disadvantage to community health networks is that its members could only make

recommendations. Health care organizations financed community network recommendations and expected to make the decisions (Wellever 2004:229-230).

Members of community health networks such as the DCHC tended to investigate and monitor health care organizations to identify problems and propose solutions. The DCHC was a community health network of volunteers that formed in 1996 in response to MVH's bankruptcy. Dukes County Health Council was made up of 32 members when it first started (Guzman 1996:2) then later of 37 members. These members included Martha's Vineyard health care organization officials, HCCs, and public officials (Guzman 1996:2; County of Dukes County n.d.a). It was formed to make organizational boundaries more porous to facilitate cooperation among Vineyard health care professionals who tended to be sequestered in their "silos." The DCHC held meetings to help highly competitive Martha's Vineyard HCAs facilitate more cooperative relations and to help resolve their common problems.

Dukes County Health Council members' networking had led to significant programs. The Island Health Plan (IHP) (that was started in 2002) was discontinued after Massachusetts used a similar model for its mandated health insurance legislation. The IHP was an attempt to form a "homegrown insurance plan" (Sigelman 2005b:1) that purportedly would have enabled Dukes County residents to afford health insurance (John Snow, Inc. 1999:1).

Unlike the IHP, the VHCAP and the IHC rural clinic remained in existence. The DCHC with the help of a group of Vineyard physicians started the VHCAP in 1999 in response to Martha's Vineyard's high rate of uninsured. As the VHCAP director (Sarah

Kuh) noted, the large number of uninsured was attributed to Martha's Vineyard's reliance on small businesses, tourism and seasonal employers who often did not provide health insurance to employees (Rappaport 2008a:1). As on the mainland, Martha's Vineyard small businesses were less apt than large employers to provide health insurance to employees. Martha's Vineyard's high cost of living made it more difficult for Vineyarders to purchase health insurance compared with Massachusetts residents.

The VHCAP made health care boundaries more porous because it helped people to gain access to health care. As Wellever might have said, the VHCAP and MVH's (and other health care organizations) two way outputs were formed when MVH recommended patients to VHCAP to help them generate payments and the VHCAP enabled HCCs who lacked money or insurance to obtain health care services. The VHCAP helped medically under-served Vineyarders when it started the Reduced Fee Plan program (in 1999) for Vineyarders who did not qualify for MassHealth, did not have health insurance and made only twice the federal government poverty guidelines (Burdick 2000:5). This program helped such Vineyarders to obtain health care from general practice and specialist physicians who provided their services at discounted rates. Though nearly all Vineyard physicians took part in this program (*Vineyard Gazette* 2000a:1A), in 2003, all 150 of this program's "slots" were full (Locke 2003e:2). That 150 slots were designated for this reduced fee program (Locke 2003e:2) suggests the likelihood that physicians used rational thinking (accounting) while they decided how many patients to accept.

The VHCAP made health care boundaries more porous when it advocated for and provided information to Vineyarders about programs that helped pay for health care and

helped take the drudgery out of meeting bureaucratic requirements. After a Vineyarder supplied the needed information, a VHCAP official filled out and electronically submitted applications for programs on behalf of the applicant (Schapiro 2002:6). The VHCAP was significant to Vineyarders such as one who claimed he would have failed to complete tedious bureaucratic wrangling had the VHCAP not “made a daunting bureaucratic experience accessible and doable” (Schapiro 2002:6). It was not surprising that Martha’s Vineyard health care organizations viewed the VHCAP as beneficial and referred their uninsured patients to this program. To be sure, helping patients who otherwise might not have enrolled in public health benefit programs brings more payments to health care organizations.

The VHCAP would not have been in existence if the US health care system were affordable, coherent, and easy to negotiate. Resources that could have otherwise been spent on health care were instead used to teach counselors who in turn helped individuals who qualified for one or more programs to negotiate this health care system (Rappaport 2008a:1, 5; *Vineyard Gazette* 2008:4-A).

Cynthia Mitchell, a West Tisbury selectwoman, led DCHC members in their efforts to open Massachusetts’s first rural health clinic, IHC (Sigelman 2005b:1). It was opened in 2004 (Sigelman 2005b:1) to provide adult primary and urgent care to low-income, uninsured and other Vineyarders who sought their services (Sigelman 2005b:1, 9; County of Dukes County n.d.c). Island Health Care provided laboratory services for routine tests such as urinalysis and pap smears and tests for pregnancy and strep infection

testing (Sigelman 2005b:9). A physician oversaw the clinic (Allen 2004; *Vineyard Gazette* 2004b:2).

Island Health Care's opening was made possible through the federal government (Sigelman 2005b:9) and the state Department of Public Health (Allen 2004). The DCHC applied for and received a federal startup grant for \$500,000 (Sigelman 2005b:1, 9). The DCHC and MVH joined efforts and obtained a primary care Health Professionals Shortage Area (HPSA) designation on Martha's Vineyard in 2002. The HPSA designation enabled Martha's Vineyard's rural clinic to open because it allowed clinics in areas of need that employed a PA or APN to pursue a Rural Health Clinic (RHC) certification. An RHC certification allowed a health care organization to obtain cost-based reimbursements from Medicare and Medicaid (Moscovice and Elias 2003:6). Also, if a patient did not pay IHC or did not pay the full amount, IHC would bill Massachusetts's uncompensated care pool for that payment (Sigelman 2005b:9).

Some study participants claimed they viewed IHC's competition with MVH as problematic, especially during winter months. Island Health Care attracted patients who likely would have otherwise sought urgent care at MVH's emergency department. On the other hand, an MVH health care trustee claimed that IHC was advantageous because it relieved MVH of part of the financial burden associated with providing services to patients regardless of their abilities to pay for health care. This and IHC's referring its patients to MVH likely motivated IHC and MVH to cooperate so that IHC could obtain federal funding. Martha's Vineyard Hospital did not reject the statement Cynthia Mitchell made to government officials that IHC has formed "a solid partnership with the

local hospital” (Brown 2013:10). This enabled IHC to be designated as a federally qualified health center and to receive a \$714,350 grant. Island Health Care used this grant to increase personnel and thereby improved Vineyarders’ access to health care (Brown 2013:1, 10).

Some Vineyarders did not bother seeking health care because they believed they could not afford recommendations such as prescription drugs. This was a serious problem for populations of Vineyarders including those ages 18 to 64 with chronic diseases such as hypertension, diabetes, asthma and mental illnesses such as depression and anxiety (Kuh 2001:15). The Dukes County prescription drug plan (DCPDP) helped open doors for Vineyarders who applied. In 2006, Dukes County⁴² networked with the National Association of Counties and formed the DCPDP. Dukes County residents who applied to the DCPDP received reductions in their prescription drug costs. These reductions ranged from small percentages to 95 percent. The average was 39 percent in 2009 and more than 45 percent in 2010 (County of Dukes County n.d.b). It also provided reductions in costs for imaging studies (ranging from 50 to 80 percent) (County of Dukes County n.d.b). This was an unusual program because the only requirement was that one showed proof of one’s Dukes County residency. There were no forms to submit, no fees to enroll, no income or age restrictions, and those with preexisting conditions were not denied (Vaughn 2006:8; County of Dukes County n.d.b). In fiscal year 2008, Dukes County provided prescription assistance to 250 Vineyarders and another 112 received emergency medical assistance (County of Dukes County 2007/2008 Annual Report).

Chapter Summary

This chapter delineated Martha's Vineyard's health care professional stratification and described Martha's Vineyard's health care professionals and health care organizations. It argued that health care professionals and HCCs ranged from elites to stigmatized populations. Health care organization networking was carried out to promote profiting while at the same time to help Vineyarders. However, many Vineyarders continued to be excluded from Vineyard health care organizations. Most, if not all, of those taking part in efforts to improve Vineyarders' access to health care would have agreed that they had worked hard and their efforts had led to some significant successes but that much remained to be done to fix the broken health care system. Many health care advocates stated publicly, during interviews, and during private conversations that it was broken because it was complicated, inaccessible for too many, and wasteful.

Chapter 4. Summary and Conclusion

We humans are utilitarians. Most, if not all of us, seek happiness. Our individual and community health, security and comfort are fundamental to our happiness. Like inhabitants of most, if not all communities, individual Vineyarders' happiness and well-being were important to the maintenance of community harmony. The achievement of goals that benefitted the single or collective actor, another individual or collective, or both the actor and others could promote community harmony. Those actions that benefitted the individual at the cost of the collective or benefitted the collective at the cost of the individual could impede community harmony and could promote suffering.

This dissertation argued that Vineyarders viewed the ultimate happiness as possessing good health and as living on or visiting that Martha's Vineyard that existed (real or imagined) during one's days of youth or during that time one first discovered Martha's Vineyard. Such Vineyarders buttressed Shils's statement (1981:195) that "views of the past may be changed through self-conscious interpretation . . . that . . . is . . . retrospectively reformed by human beings living in the present" (Handler and Linnekin 1984:276). Many Martha's Vineyard community activists promoted a return of "real," imagined, or invented (Hobsbawm 1992:7) attributes of yore and hoped their children could grow up in a similar community their parents enjoyed. Such invented traditions

often held an “ideological content” (Handler and Linnekin 1984:276 citing Shils 1981:195) and could be viewed as “old uses in new conditions” (Hobsbawm 1992:5).

Community Boundaries and What They Meant

Emphasizing community contents (meanings), as opposed to forms (ways of behaving or ostensible function) (Cohen 1985:20, 44, 98), “neatly sidesteps the definitional problems posed by the search for a structural model of community as a specific form of social organization” (Hamilton 1985:9). Vineyarders, through participant observation, interview data and archival data, demonstrated that the definitional boundaries of the term “community” could be best thought of as fluid, diffuse, and malleable (Cohen 1985:20, 91, 18) symbolic constructions (Handler and Linnekin 1984:273) that “existed” in the minds of Vineyarders. Viewing communities as such allows a social scientist to adequately study communities even though community members tend to hold varied definitions of their communities.

Perhaps fluid and diverse community boundaries explained, in part, the difficulty several study participants had with the interview item, “What do you identify as your community on Martha’s Vineyard?” Some claimed that it was a difficult question and many took much time to formulate their varied responses. It seemed ironic that several who had discussed their communities then responded to this question with, “what do you mean by ‘community’?” However, it is likely that some responders were trying to reach inter-rater reliability while they assumed that a rigorous definition of “community” was used in this study. Assumptions of inter-rater reliability during discussions about

“community” issues may have taken part in Vineyarders’ shared sense of a community connectedness. Vineyarders often lived harmoniously until another’s actions (discussed earlier) threatened their sense of ideal (or satisfactory) community life.

While this dissertation examined “community” as a symbolic construct, it viewed Vineyarders’ values as demonstrated by their actions. This content analysis was framed along a utilitarian values continuum. Exploitative egoistic utilitarians were viewed as located on the far left of the continuum and collectivistic universalistic utilitarian values on the far right. It argued that community members exhibited egoistic and collectivistic utilitarian values by their actions (on the basis of statements they made and other actions). Some Vineyarders viewed particular actions as conducive to community harmony while others viewed these same actions as impediments to community harmony. For example, some viewed zoning as beneficial, while others viewed zoning as too restrictive, especially in areas where the zoning regulations were more strict (e.g., historic, conservation and other districts). Some Vineyarders praised land conservation efforts while others stated that such conservation promoted scarcities of land and drove up housing costs. A few claimed that conservation efforts took place only in wealthy neighborhoods. Those who promoted housing for Vineyarders who could not afford to buy or rent housing at going rates may have been thwarted by cries of “NIMBY” (not in my backyard). Some Vineyarders expressed the belief that those who promoted access to free or reduced cost health care promoted laziness or irresponsibility.

Many, if not most, Vineyarders viewed good health as necessary to promote one’s happiness. Many Vineyarders, including some HCCs and especially health care

professionals and health care activists, claimed that the health care system was flawed, broken, too complicated, and wasteful. Several Vineyarders attributed this to pharmaceutical, insurer or local health care organization' too high a focus on profiting. Study participants and Vineyarders encountered during participant observation often expressed their appreciation for their Vineyard and mainland health care providers. Many Vineyarders were satisfied with their health care organizations and more often with their health care professionals.

Cyclical Health Care Organization and Community Relations

Chapter 1 argued that health care provider and community relations were strained during periods when health care power brokers had deceived the public, instituted harsh and contentious working conditions, fired health care professionals unfairly, silenced employees, and paid unfair wages. Vineyarders vigorously defended their health care professionals during such periods. As Chapter 1 argued, firing and underpaying Vineyarders or driving them away could produce harsh results. Having one's income discontinued or receiving low wages put Vineyarders at risk for being economically forced to relocate to the mainland. This might have been a significant factor in Vineyarders' strong reactions (Chapter 1) to unfair firings and unfair wages.

Vineyarders' recollections of Martha's Vineyard's health care went back to the 1980s when a second visiting nurse organization opened on Martha's Vineyard (as discussed in Chapter 3) and when Edward B. Hanify, Jr. left MVH (discussed below). A recent event and my coming across a 1980s newspaper report led to the realization that

MVH's recurring failed relations with the overall community had been occurring cyclically. Also, these failed relations appeared to occur as a result of high-ranking officials' business-as-usual practices that were being shielded from the public. The business-as-usual discussed below tended to point toward exploitative utilitarian values. The hospital's trustees underscored such business-as-usual during the early-1980s when they tried to protect Hanify after he committed fraud. Those trustees tried to prevent the firing of Hanify, though he had falsified his educational credentials. That board chairman's claim that the board had not viewed such fraud as producing a crisis at MVH (Breslauer 1980b:9) suggested that committing fraud was within the board's usual conduct. It appears that these trustees viewed such deviance as not problematic as long as knowledge of it remained within the confines of the good-old-boys⁴³ club.

During Hanify's tenure, MVH power brokers clearly were trying to deceive the public. The *Vineyard Gazette* portrayed their contradictory accounting of events and their utter lack of integrity. Their contradictions included that Hanify held a Master's degree in Public Health, as stated by Hanify when he applied to MVH and by MVH's principal officers in April 1980 (Breslauer 1980a:1). Then hospital officials claimed that Hanify had admitted that he did not hold a Master's when MVH's selection committee (of new employees) interviewed him in July 1979 (Breslauer 1980a:1). That following September, hospital officials claimed that Hanify "discovered" that he did not have this degree (Breslauer 1980a:1). Joint conference committee meeting minutes "showed" that Hanify "thought he had actually been awarded the degree" (Breslauer 1980a:1) but that he had overlooked that a thesis had been required (Breslauer 1980a:6).

As discussed in Chapter 1, the mid-1990s brought the next huge crisis of confidence in MVH leadership. Once again, MVH officials tried to deceive the public. In June 1996, “board members said they were anxious to ‘dispel the myth’ that the financial condition of the hospital was in any way precarious” (Wells 1997c:5). By that July, the public learned that MVH’s endowment money (\$6 million) had been spent (Wells 1997c:5; Wells 1996b:3; Wells 1997a:1). By that December, MVH had announced it was bankrupt (Wells 1997c:5). Five years later, a newspaper reported that high-ranking hospital officials and the Dukes County manager may have committed fraud surrounding the inter-municipal agreement (Sabatini 2001:1, 12) (as discussed in Chapter 1). Martha’s Vineyard Hospital improved its relations with the community starting in 2002 (as observed at an MVH forum), before its capital campaign to raise funds for a new hospital building. These good community relations enabled MVH to raise the entire cost to build the new hospital (Seccombe 2007b:1-B).

The most recent business-as-usual cycle started in 2017 when MVH’s CEO (Joe Woodin) was abruptly fired not long⁴⁴ after he had relocated from Vermont for MVH’s CEO position (Wells 2017b:1). Due process was absent (Wells 2017b:1; Brighish 2017b:A-13). This firing was particularly harsh because Woodin had purchased a house on Martha’s Vineyard five months before he was fired (*Martha’s Vineyard Times* 2017:A-12; Wells 2017b:1). When MVH board chairman (Tim Sweet) and the interim CEO (Tim Walsh who had retired from MVH in 2016) provided implausible and vague explanations, hospital and community relations deteriorated (Wells 2017a:1; Wells 2017c:4; Lent 2017a:A-13 *Martha’s Vineyard Times* 2017:A-12; Brennan 2017:A-4). A

longtime Vineyard physician “cut to the core” when he asked “how can an institution whose mission is to care for people treat its leader in such a careless and unprofessional manner?” (Yukevich 2017:13). Woodin claimed that he had crossed Sweet who then fired him in a “power play” (Wells 2017b:1).

Vineyarders’ reactions to Woodin’s firing suggested that Woodin was fired because his policies leaned less toward exploitative utilitarianism compared with the policies of those who took part in his firing. Unlike the board, some Vineyarders claimed that Woodin shared a vision similar to that of MVH physicians and nurses, MVH patients, and Vineyard community leaders (*Martha’s Vineyard Times* 2017:A-12; Brigish 2017a:A-12; Lent 2017a:A-13). Mid-level MVH employees believed that Woodin had been trying to change a “long-entrenched internal culture that resisted change” (Wells 2017c:4). Woodin was promoting MVH transparency, responsiveness and accountability to the Vineyard community overall (Brigish 2017a:A-12; Lent 2017b:13). Perhaps he also was trying to undermine conflicts of interest at MVH. These included Rachel Vanderhoop, MVH Director of Development (Sweet’s wife) who was paid more than MAG’s Director of Development⁴⁵ (Wells and Breslauer 2017:7; Glassdoor 2008-2017). Perhaps Woodin was trying to hasten the implementation of changes that required HCT term limits (Wells and Breslauer 2017:7). These bylaws stipulated that the board chairman could stay until 2021, though he had been the chairman for the past seven years and he (along with the board treasurer) had been on the board since 1997⁴⁶ (Wells and Breslauer 2017:7). As experts in board governance explained, trustee term limits help an

organization to use new approaches and to promote HCT responsiveness (Wells and Breslauer 2017:1, 7).

Term limits would have prevented some entrenchment of good-old-boy club networking and may have also prevented some attempts to deceive the public. Sweet and Vanderhoop did not promote Vineyarders' confidence in their leadership when they falsely claimed that Woodin had resigned (*Martha's Vineyard Times* 2017:A-12; Brennan 2017:A-4; Wells 2017b:1). Vineyard newspapers reported that Sweet had asked Woodin to sign a fraudulent letter that claimed he was resigning for personal reasons (Wells 2017b:1; Brennan 2017:A-4; *Martha's Vineyard Times* 2017:A-12). Sweet and Vanderhoop also claimed that Woodin's firing was a board decision, though it appeared that two or more board members were not aware of this firing until after the decision had been made (*Martha's Vineyard Times* 2017:A-12). The board chairman tried to deceive the public when he shifted blame to Woodin because Woodin had not covered for Sweet when he lied to the public about Woodin's resignation (Brennan 2017:A-4; Wells 2017b:14). He chastised Woodin for not maintaining MVH's insularity surrounding his firing. Sweet claimed:

What happened was a very messy fallout and we feel heartsick about it. The error is ours – it never occurred to us that he [Woodin] wouldn't take the opportunity to do what is best – that's why there were mixed messages and for that we apologize (Wells 2017b:14, brackets added).

During the 1980s, that board chairman (Spaulding) had tried to deceive the public with his claim that the media were blameworthy for the Hanify crisis (Breslauer 1980b:9). It seemed that in Spaulding's eyes the media were blameworthy, not for the crisis, but for

making it difficult for MVH to shield the public from its wrongdoings. Public “ignorance is bliss” seemed to be Spaulding’s sentiment concerning MVH insularity.

It is no wonder that MVH is an insular organization (Breslauer 1979a:1; Reston 1980:16; Gay 1996b:7; Wells 1997c:1, 5; Crafts 1999:15; Bochow 2002:9-10; Brennan 2017:A-4; *Vineyard Gazette* 2017b:12) in light of MVH’s business-as-usual conduct discussed here. It appears that such insularity was a significant factor during the early–1980s when MVH trustees voted unanimously to use MVH’s internal quality evaluations committee instead of an outside management consultant firm to investigate Hanify’s credibility and performance (Breslauer 1980b:1). Also, the board chairman (James Spaulding) claimed that trustees had failed to ask Hanify to resign because Hanify might have sued MVH in response (Breslauer 1980a:6). Collecting information in responses to such a lawsuit could have (and probably would have) led journalists to uncover significant information about the inner workings of MVH.

The Vineyard newspapers showed similarities in how MVH power brokers’ actions were played out during each period of deteriorating MVH and community relations. As discussed above and in Chapter 1, organizational problems tended to be hidden from the public for as long as possible. Organizational insularity protected self-motivated, aberrant health care power brokers from public scrutiny. It enabled MVH trustees to write a large severance pay package for the MVH director (Wells 1997c:5). It enabled the director to be in charge of her MVH pension fund (in ways that may have been problematic) and to provide generous severance pay packages for senior managers while they were draining MVH of its resources (Wells 1997c:5). It enabled MVH and the

Dukes County manager to amend the terms of the inter-municipal agreement after it was signed. The public learned of these actions thanks to the Vineyard newspapers.

However, by the time the public learned about a controversy, the damage may have been significant. For example, reports about MVH officials who invaded MVH's endowment since 1980 (Wells 1996a:1, 9) did not become public until reported in 1996 after the endowment (some of which was restricted) was depleted (Wells 1996b:3; Wells 1997a:1, 9; Wells 1997c:5).

Health care power brokers' tactics also included stalling when confronting a crisis. Perhaps their implausible statement that they wanted more community input (Brennan 2017:A-4) was a stalling tactic and a means to placate the community overall. Investigations were used as stalling tactics. After Woodin was fired, the interim CEO claimed that MVH was planning to hire a consultant to investigate the trustee's communication and role in Woodin's firing (Brennan 2017:A-4). It appears likely that a consultant would have been used to stall the reporting of findings that could negatively reflect MVH. Such a report would not be completed until two months after the consultant is hired (Brennan 2017:A-4). Ideally (for health care power brokers), by the time the investigation would have been completed, Vineyarders' ill sentiments perhaps would have been attenuated or another controversy would have directed Vineyarders' attention elsewhere.

Investigations tend to be a safe method. Internal or external investigators tend to produce results that favor the organization being investigated. After all, the health care organization pays their employees or outside investigators to conduct the evaluation.

Also, it is unlikely that a government investigation would report scathing results on an organization, such as MVH, that is an American Hospital Association member. That is because the AHA provides significant donations to political campaigns (Pollack 2016:1).

Around the time Hanify was hired with false credentials, *Vineyard Gazette* editors pointed out some of the processes stated above:

Now, finally, we have a decision from the hospital's board of directors. . . . Call in outside consulting help. . . . Evaluate the performance And, let's wait. Let's by all means wait until September – for another full two months or more – to hear that evaluation report from that yet unchosen consultant.

That is the apparent decision of this board . . . devised within the narrow strategy persistently pursued by the board's top officers. It is a decision taken in a moment of supreme crisis. . . . It fails to meet the immediate crisis. . . . So what do we hear? We hear demands for more time. We hear more talk about the need to evaluate We agree there is need for further evaluation. But now the time has come to evaluate the performance of the hospital's board of directors. . . . Instead of cooperation and good will, we find legal suits threatened, charges hurled back and forth, campaigns mounted and poisoned by smears and unsupported allegations, and narrow, short-sighted political tactics substituted for the long-range interest of hospital and community The hospital and the Vineyard cannot wait yet another two months for outside consultants to tell us what we already know (Hough and Reston 1980:1, 2).

It appears that such exploitation in a health care system that may place the health of employees second to healthy profits is what led several Vineyard health care professional study participants to claim that their organizations produced unhealthy working conditions. A healthy work environment entails keeping agreements, maintaining open communication, and promoting and enabling professionals to maintain their professional integrity. While the unhealthy working conditions discussed above were a result of Vineyard locals, some factors stemmed from the mainland, as Chapters 1, 2, and 3 argued.

Mainland Influences on Martha's Vineyard Health Care Organizations

Partners was a mainland source that both improved and impeded access to health care on Martha's Vineyard. It had brought significantly more health care technology to MVH and thereby enabled Vineyarders to stay on Martha's Vineyard to obtain such services. That made MVH more profitable while Partners provided financial back up and freed MVH from worrying about another bankruptcy in this health care climate of ever more reductions in reimbursement rates. However, as Chapter 1 argued, Partners used its market clout to maximize its insurer reimbursements which, in turn, drove up health care costs in Massachusetts (Allen et al. 2008; Allen and Bombardieri 2008; *Boston Globe* 2008; Mahar 2006:127-128 citing Cuellar and Gertler 2005:214). Additionally, Massachusetts health care reformers disregarded the issue of rising health care costs when they crafted Massachusetts's mandated health insurance law. This was not surprising given that Partners and Blue Cross/Blue Shield "were intimately involved in crafting the health reform law" (Denison 2007:63).

Uwe E. Reinhardt explained the fundamental problem with a US health care system and a set of national policies that relied on charities to inadequately cover the costs of health care for those who could not afford it. He pointed out that US policies produced sometimes humiliating processes that some were required to undergo to gain access to health care:

as a matter of conscious national policy, the United States always has and still does openly countenance the practice of rationing health care for millions of American children by their parents' ability to procure health insurance for the family or, if the family is uninsured, by their parents' willingness and ability to pay for health care out of their own pocket, or if the family is unable to pay, by the parents' willingness and ability to procure charity care (Reinhardt 2005:25).

Some Martha's Vineyard "health care beggars" (Reinhardt's 2005:25) claimed they were ashamed that they could not afford health care for themselves or their families. They either avoided health care services or underwent the humiliating process of trying to obtain it.

Several claimed that using free health care services would have prevented others who were worse off from obtaining needed services. Put another way, they did not want to be burdens to their communities. Some Vineyarders claimed they probably would have qualified but refused to seek assistance. Conversely, some who probably would have qualified did not try to receive assistance. Clearly, such a system disrupts communities and human integrity. As on the mainland (Barth 2000:29), study participants and other Vineyarders suggested that on Martha's Vineyard, people seeking such benefits tended to be categorized, not necessarily according to their needs, but according to their levels of entitlement or exclusion.

Some claimed that they avoided accepting free health care services to prevent humiliation by the significant possibility that other Vineyarders would hear about it. The humiliation from having to accept charitable or public health care could run deep. Early in this field research, an elderly Vineyarder claimed that he believed it was wasteful to conduct this study in a place like Martha's Vineyard instead of in an impoverished

country. Toward the end of this fieldwork, he claimed that his wife had been permanently and severely disabled. He claimed that, since then, his experiences with the health care system led him to recognize the value of conducting this research on Martha's Vineyard. He claimed that it was distressing to be required to spend down a majority of his life savings before his wife could qualify for public assistance for visiting nurse care. He became visibly upset when he discussed a mailing he received from the visiting nurse organization from whom his wife was receiving services. It was a request for a donation to that visiting nurse organization. He, like many Vineyarders claimed that he was a good citizen who did the right things, worked hard and paid his way throughout his life. Yet, such Vineyarders could not access or were not willing to access health care if, thereby, impoverishment could ensue.

Isolation of Those Who Could Not Afford Health Care

Failure to afford meeting one's needs could be worse in places such as Martha's Vineyard where poverty tended to be hidden and where relative poverty tended to be acute. A study participant claimed she felt embarrassed and isolated by having had difficulty affording health insurance. After reading an article in the newspaper, she realized she was not alone. Carol Koury claimed that none of those 20 percent of respondents who claimed in a mid-1980s study that they avoided health services because they lacked money or health insurance (*Vineyard Gazette* 1986:1 citing League of Women's Voters) were present at a public discussion about such issues. Koury rhetorically asked, "How could you possibly stand up in such a public place and say to

that audience, ‘I’m one of the people you’re talking about?’” (*Vineyard Gazette* 1986:1). Several audience members (like study participants in this study) confirmed the notion that people were ashamed or too proud to admit such failure (*Vineyard Gazette* 1986:6) and thereby, tended to avoid health care services unless they could pay their way or were in dire straights.

Those who could afford most, if not all, of their health care were most often those who easily could access health insurance. Well-paid employees were more apt than low-paid employees to hold employer-sponsored health insurance (Claxton et al. 2014:56, 57). As discussed in Chapter 1, powerful health care interests tried to monopolize health care and then institutionalized a health care system that is expensive, disorganized, difficult to access, and not maximally effective (Bentley et al. 2008:650-651).

As discussed in Chapter 2, our “skewed economy . . . distributes not just enormous wealth but also enormous debt” (Jain 2013:11). This had led many Americans to bankruptcy (Himmelstein et al. 2009:1, 4; Himmelstein et al. 2005:W5-63, 73 n. 12) and some Vineyarders to be forced to relocate to the mainland. Gudeman (2001) noted that debt and credit could “determine who stands inside and outside of community borders or who stands above or below” (Peebles 2010:228). This was literally the case on Martha’s Vineyard for those who had been forced off-Island as a result of medical debt. A study participant lamented that her best friend had been driven from Martha’s Vineyard because of debts from her hospitalization. A study participant, whose medical expenses rose markedly after his wife acquired a degenerative disease, claimed he and his wife probably would be required to sell their house and relocate to the mainland to raise

money to pay for her health care. Sadly, a “for sale” sign was noted while driving by their house. Also, a large dependence on debt drains community resources and prevents capital from being used for more productive purposes (Williams 2004:96).

Local Efforts to Resolve Difficulties Accessing Health Care

As Chapter 3 argued, Martha’s Vineyard health care organizations promoted Martha’s Vineyard communities significantly for those who could access them. Vineyarders depended on their health care providers to enable them and their loved ones to stay on Martha’s Vineyard for health care, to return sooner to Martha’s Vineyard if hospitalized on the mainland, and to visit Martha’s Vineyard without being isolated from a hospital. Vineyarders showed a significant interest in their health care organizations. Perhaps this stemmed from the limited choices of Vineyard health care providers and the difficulties associated with traveling to the mainland.

Since the government tended to leave many behind and tended to offer complicated “solutions” to problems, local efforts to improve access to health care had been formed. As discussed in Chapter 3, Moscovice and Elias argued, Martha’s Vineyard was unique because it tried to resolve a widespread US problem on a Vineyard scale:

Communities elsewhere in the country have relied on government bodies to coordinate health care and subsidize affordable health insurance. . . . But on the Vineyard, a close-knit community where most people know each other’s faces if not their names, residents organized a grassroots effort to create a solution (Moscovice and Elias 2003:9).

The US and state governments’ efforts tended to benefit nonprofit and for-profit health care organizations while they often left HCCs to fend for themselves. While government

programs enabled more populations of Americans to gain access to public health insurance benefits, government officials had done little to prevent exploitative patient gouging and the ensuing breakdown of US communities. Legislation the government created such as the Bayh-Dole Act (Government Patent Act of 1980) made it easier for pharmaceutical corporations to gouge patients and to use government-subsidized research to further their profits (Angell 2005:xxvii, 7-9, 57, 69-71, 101-102; Washington 2011:39-40; Oberlander 2003:W3-395; Geyman 2004:147-148). Also, government officials enabled exploitative insurers to ration health care. Such rationing did not curb health care provider abuses. Rather, it further impoverished health care recipients and further enriched insurers.

How is it that social policy scholars (Colin Gordon 2003:7 citing Korpi 1989:311-312; Himmelstein and Steffie Woolhandler 1990:22-23; and Vincente Navarro 1989:887-898) suggested that the government frustrated the majority's hopes and values instead of representing them? As Chapter 3 argued, American policymakers and entrepreneurs had institutionalized a system in which US "democracy" benefitted those who "donated" to political campaigns and those who received donor funds⁴⁷ (Geyman 2004:202 citing Phillips 2002:325; Schweizer 2013:58; Bellah et al. 1991:131). Those who provided large funds to political campaigns framed issues and impacted policies (Griesemer 2013:25, 36), influenced which candidates ran for public office (Bagdikian 2004:10), influenced government officials to impede competitors (Haley 2003:2, 6, 9, 10; Baer 2004:324; Brown 1980:8, 9), and influenced legislators' decisions about which legislation appeared, disappeared, or failed to emerge (Bagdikian 2004:x). Special interests, in

concert with political office holders, maintained high health care costs (Oberlander 2003:W3-395, W3-399; Oberlander 2006:252) and prevented a single US health insurer and universal health care coverage from being introduced into health care reforms (Oberlander 2003:W3-394, W3-395; Oberlander 2005:11; Madison 2005:53, 54).

Health care disparities are not likely to disappear under a system where few have access to significant wealth and universal access to health care is nonexistent. Census data showed that the 6.7 percent of Martha's Vineyard residents impoverished in 1990 increased to 7.3 percent in 2000 and to 8.6 percent in 2010 (Martha's Vineyard Commission 2013 Part 1:28 citing US Bureau of the Census 2006-2010). An affordable system of financing health care that keeps health care inflation in check would be necessary to provide health care without the fear of the need for health care that prevailed for too many on Martha's Vineyard (and elsewhere in the US). A mainland physician (private conversation, February 12, 2018) claimed that a socialistic system where physicians would be paid less than they are today would be feasible if the government were to enable students to complete medical school at low costs.

A longtime Vineyard nurse stated that universal access to national health insurance would benefit the majority and would reduce health care costs significantly (Brennan 2008:13). Universal national health insurance would improve the US economy because Americans would have more spending power (Brennan 2008:13). It would preclude rising employee health insurance costs increasing state and town budget deficits (Fein 2005:1, 6; Rohr 2007:1, 4; Myrick 2008:10; Cheney 2011:29; Myrick 2011a:1). It would preclude, as the literature and as several study participants pointed out, avoiding

health care services because of costs (Brennan 2008:13; Stoll and Bailey 2009:10 citing Kaiser Commission on Medicaid and the Uninsured 2008), difficulty paying for health insurance, fear of needing health care services, and fear of the unknown because one is not informed of one's health care costs until after the care is rendered. It would preclude requirements to change medications, physicians and other health care providers because one's employer changed its insurance carrier (Seccombe 2009c:1, 16). It would preclude one having to change insurers if one's health care organization ends its contract with one's insurer. Changing insurers could entail underwriting with a new insurer that would require one to receive health care services on the mainland (Seccombe 2009c:1, 16).

Many costs impede health care, such as:

Health insurance premiums . . . and . . . hidden costs. Almost a third of our health insurance premium goes to administrative costs, not health care. Some of our premium pays for those who lack health insurance and seek so-called free care in hospital emergency rooms. In addition, each of us who pays federal and state taxes and owns or rents a home here on Martha's Vineyard is paying for the health care insurance of every federal, state, county, and town employee. And everything that we buy, from a new car to a box of cereal, includes the cost of health insurance for the workers who made, transported, or sold that product to us (Brennan 2008:13).

According to Peter Slavin (president of MAG), private insurance companies spent ten to 30 percent of its budget on administrative costs while Medicare spent only five percent (Meyers 2009).

Unless the system of political campaign finance is changed, large political campaign donors will continue to use the government to exert their wills (Gordon 2003:8-9) in spite of the consequences to the majority. Money will continue to be funneled from the public sector to for-profit and nonprofit health care organizations while many cannot

access health care, become bankrupted if they and their family members become sick, or pay hidden costs such as those above.

As it stands today, the system provides no incentives to prevent government and corporate officials from promoting health care interest power brokers. Rylko-Bauer and Farmer (2002:492) argued that “achieving equity and eliminating inequalities in health care is unattainable in a competitive market structure where profits determine policy.” Without fundamental changes, political office holders will continue to extort favors or use the law to punish those who go against them⁴⁸ (Schweizer 2013:55-56). Government and corporate officials will continue to strengthen their “revolving door” (Geyman 2004:209; Haley 2003:6) networking. Daniel Haley (2003:xv), a former member (1970-76) of the New York State Legislature claimed that two-thirds to three-quarters of FDA retirees became employees of pharmaceutical companies. As stated in Chapter 1, such networks explain FDA officials whose research was not stringent when approving drugs.

Summary of Chapters

Chapter 1 argued that “culture” could be viewed on Martha’s Vineyard as Cohen (1985:98) defined it (“the community as experienced by its members”). Vineyarders attached meaning to the cultural symbols they used to define their communities and to define “other” communities. Vineyarders were highly committed to living on Martha’s Vineyard. They viewed Martha’s Vineyard’s strong communities as special and unique.⁴⁹ They valued their Vineyard communities so much that they made significant trade-offs to live there. Their sense of Martha’s Vineyard community idealism led them to trade more

“cash flow” or expendable income for living and working on (or retiring on) and being integral constituents of Martha’s Vineyard’s relatively small, intimate communities. As stated in Chapter 1, Martha’s Vineyard’s high cost of living led Vineyarders to forego living in larger, more comfortable houses, driving better automobiles, and for some, not living in poverty or not moving twice a year. Vineyarders showed a commitment to participating in their community “in terms of *its* problems and *its* future” (Lynd and Lynd 1937:188 italics in original). Vineyarders’ commitments to living on Martha’s Vineyard and struggling with its high cost of living suggested that they sought qualitative wealth over quantitative wealth.

Vineyarders tended to view economic disparities as the most pressing problem on Martha’s Vineyard because it economically forced friends, loved ones and Vineyarders, who maintained qualities that made Martha’s Vineyard what it “is,” to relocate to the mainland. If too many relocated, the few “old guards” left on Martha’s Vineyard would not be sufficient in number to oppose threats to Martha’s Vineyard communities that Vineyarders often viewed as stemming from “Elsewhere, USA.” Some claimed that it was already too late to stem the tide. Threats to Martha’s Vineyard “community” fueled Vineyarders’ tenacity when they expressed their commonly held symbolic forms and while they made efforts to reduce nefarious impacts to their communities. Their commonly held symbolic forms motivated Vineyard activists. Some made efforts to benefit all who chose such benefit. This would be the case for private tracts of land that conservation organizations purchased and maintained for public use. Others’ efforts benefitted only some individuals, such as those who were lucky and won reduced cost

housing through the housing lottery, qualified for reduced rent, or qualified for health care or health insurance at a reduced cost (that one could afford).

Chapter 2 argued that previous generations of today's medical doctors pushed what emerged as today's alternative health care providers to the margins. This led that day's alternative health care providers to form encapsulated communities, some of which today's generations of practitioners had maintained. Several communities of alternative health care providers existed on Martha's Vineyard. This chapter argued that the ideological boundaries that separated mainstream and alternative medical ideologies were more rigid than their health care practices boundaries. Mainstream medicine power brokers legitimated their efforts to discredit alternative medicine modalities with claims that they were not scientific. But rather, their claims pointed toward their trying to monopolize health care and drive up costs.

In Chapter 2 it was argued that some health care professionals performed tasks outside their job descriptions to enable Vineyarders to access health care. For example, they gave patients rides to mainland health care organizations. Conversely, it argued that health care power brokers' actions suggested that they were subscribing to exploitative utilitarian values. Chapter 2 argued that the actions of health care, medical professional organization, US government official, and some research organization power brokers played significant parts in diminishing health care efficacy for Vineyarders and other Americans. Exploitative utilitarian values were evident because health care power brokers promoted significant personal and corporate gain while their policies led many HCCs to lack adequate health care. Such actions had led to health care disparities. Such

actions included insurer “cherry picking” and other policies with little focus on policies that could have promoted improved health and reduced morbidity and mortality. Rather, whether or not possessing health insurance, many Vineyarders had feared obtaining health care services because they feared being saddled with crushing debt. Only those with the best insurance policies or with great wealth were free from worry. In Martha’s Vineyard’s (and USA’s) “free” market, the freest from worry are the wealthy (Berry 1996:41). It was not by accident that health insurers promoted a fragmented, costly health care system that often served most effectively those patients who needed health care services the least. Chapter 2 discussed some of the mechanisms Vineyard and mainland power brokers used to include people within or exclude people from Martha’s Vineyard health care communities. It argued that the hospital (and MVCS according to an MVCS official) tried to attract Vineyard elites and those Vineyarders who made up a good case mix.

Chapter 2 argued that health care disparities and the US and Massachusetts governments’ failure to promote health care policies that enabled all Americans to obtain adequate health care led to community divisiveness and community breakdowns. Vineyarders had mobilized to try to resolve difficulties obtaining health care. The collectivities they formed often had promoted egoistic utilitarian solutions. This was likely because Vineyarders tended to recognize the political infeasibility of making structural changes that health care power brokers would reject and crush.

In Chapter 3 it was argued that health care professionals’ access within the hierarchical order depended, in part, on whether their work was stigmatized, or as

Ashforth and Kreiner (1999) put it, if it was “dirty” or “clean” (Mills, Drew, and Gassaway 2007:4). As Bridget Anderson (2000) noted, paid care included jobs that were associated with dirty work (Simpson et al. 2012:1). Dirty work tasks required one to touch and smell undesirable things such as excrements and to work with “unspeakable materials” (Höpfl 2012:21). Those who were employed in dirty occupations may have been viewed as socially undesirable people and their roles as humiliating, debased, and undervalued (Höpfl 2012:21, 31). However, occupations such as nursing that provided personal satisfaction and whose status occupants also carried out good tasks were viewed as easier to endure than those of socially unacceptable occupations (Hughes 1951:295). Ashforth and Kreiner (1999) noted that health care practitioner occupations, including dirty ones, were viewed as possessing less “moral taint” (Mills, Drew, and Gassaway 2007:4) than the banker (since the US banking crisis) and stripper occupations (Höpfl 2012:21; Mills, Drew, and Gassaway 2007:4).

Chapter 3 argued that Vineyarders had mobilized to promote egoistic utilitarian solutions to Martha’s Vineyard’s isolation from tertiary and from several kinds of secondary health care services. It discussed ways in which Vineyard health care organizations networked. While Vineyard health care providers were highly competitive and highly insular, they networked if doing so promoted further profiting for each party within the network. Those that formed business ties networked with local and mainland health care organizations and helped Vineyard health care providers to capture more patients and more profits. Such networks also significantly helped to mitigate

Vineyarders' isolation from mainland health care services (and Chapaquiddick from Martha's Vineyard health care services).

What This Dissertation Argued

This dissertation argued that Martha's Vineyard "community" was best thought of as a symbolic construct that is not "real" except in the minds of many Vineyarders. It argued that values were best demonstrated according to Vineyarders' actions and according to their explanations of their actions. It described ways in which Vineyarders legitimated their actions and whether their words accurately described their actions. The recurring conflicts demonstrated above were explained by utilitarian values. Community members drew on their sets of values when they determined whether another deserved to be included, excluded or stigmatized. Vineyarders tended to include within their communities those who shared compatible values and excluded others whose values were not compatible with theirs.

This dissertation argued that utilitarian values were well entrenched in US and Martha's Vineyard health care. Utilitarian values were viewed as possessing two variations along a continuum whose extremes were exploitative (egoistic) utilitarian and altruistic (collectivistic) utilitarian values. This dissertation argued that the many health care factors discussed in these pages is perhaps what led the late US icon broadcast journalist and beloved Edgartown property owner, Walter Cronkite, to claim (as many Vineyarders would have agreed) that "America's health care system is neither healthy, caring, nor a system" (Sakai and Kheir 2014:11).

Because government organizations had done little to even disparities (and did much to promote them), Vineyarders had mobilized. They had formed networks that promoted access to housing and health care for some “deserving” Vineyarders or for those who qualified according to specific criteria. Such networks were limited to Martha’s Vineyard or stretched across Martha’s Vineyard’s ocean boundary. Such networks included business networks and community networks. In general, while not mutually exclusive, business networks were formed to promote profits and community networks to improve conditions for community members.

Contributions to Anthropology

This dissertation addressed “community” and “values,” concepts that anthropologists and other social scientists had found to be problematic. It affirms that anthropology is of value to understanding communities and cultural values. It utilized social anthropological concepts that explained how a concept such as “community” that arguably is not “real” and does not exist (that is, cannot be objectively verified) could hold significance in the promotion of ideals and actions. Such concepts included Cohen’s (1985) symbolic construction of community theory, Howard Newby’s (1980:259) “cultural encapsulation,” and Fredrik Barth’s (1969:10, 15) notion of boundaries. It utilized such concepts to extract cultural values from a content analysis of spoken communication and other actions.

This dissertation adds to anthropological conversations about what cultural values could be extracted from the ways in which we include and exclude vulnerable members

of our communities and societies and from the delivery and financing of health care. It adds significance to our discussions about ways in which communities are experienced by their members. It affirms that anthropology could be used to illuminate ways in which health care and other power brokers have shaped communities. Deborah Stone (2002:63) explained such mechanisms. Stone (2002:63) and Hoffman (2010:45) argued that insurers had shaped our culture, in part, by their roles in the promotion of some and the marginalization of other health care ideologies. More specifically, insurers played a significant part in such promotions (and marginalizations) through their reimbursement policies that helped to empower some kinds of health care practitioners, led to their dominance achieved in significant part by their exertions of political technologies, their widely held and deeply entrenched ideologies, and their significantly enlarged market shares (Stone 2002:63). Judith Walzer Leavitt (1986) noted that giving birth in hospitals became widely practiced after insurers began covering such costs (Stone 2002:64). Some study participants claimed that their insurers motivated their treatment choices because their insurers agreed to cover expensive treatments such as surgery but refused to cover less invasive, significantly less expensive procedures.

Those who had exploited individuals and communities, such as insurers who denied coverage of life-saving treatments, have shaped communities of activists. Insurance policyholders had mobilized in their efforts to pressure insurers to improve their health care reimbursement policies such as denials of coverage that could have led to fatalities (Stone 2002:65). Also, insurers have played a role in promoting individualistic and collectivistic ideologies about inclusion in and exclusion from health

care communities and about responsibility to the individual, the collective, and those less fortunate (Hoffman 2010:45; Stone 2002:73). They have stimulated questions such as, who deserves public assistance, to whom adequate health care and health insurance should be made available (Stone 2002:73), and where individual responsibility for covering the costs for health care lie (Hoffman 2010:45). This dissertation could help to promote conversations about health care access that examines social and cultural factors rather than focusing solely on economics, “the dominant paradigm for analyzing insurance” (Stone 2002:74) and other health care policies. This kind of analysis allows questions such as those asked here that take into account values, cultural factors, and structural conditions that make it easy or difficult to contribute to the commonweal as fully-engaged community members. Michael Tanner (2006:24) pointed toward the use of social scientific tools that could be used to help promote improvements in health outcomes. He stated that:

evidence that insurance coverage or access to health care leads to better health outcomes is uncertain at best. Evidence suggests that those without health insurance do receive less care than those who are covered. However, there is also substantial evidence that culture, education, and lifestyle are at least as important as lack of insurance in determining outcomes (Tanner 2006:24).

This dissertation contributes to the body of social anthropological community studies. Martha’s Vineyard was an excellent venue to conduct a study of a community that many regarded as a “fish bowl.” Vineyarders tended to hold themselves to high standards because, real or imagined, “everyone” (on Martha’s Vineyard) knew them and “everyone” had remembered or had heard about their accomplishments *and* their

downfalls. The all-watching, community gaze toward Martha's Vineyard's health care organizations was significant in producing a large body of archival data.

This Martha's Vineyard ethnography was significant also because it validated some anthropological theories. Vineyarders formed collectivities in their efforts to resolve barriers to health care and to stem mainland incursions and other factors that they viewed as threatening to their well-being and their community ideals. Vineyarders often excluded others they believed were a threat to their Martha's Vineyard community ideals. Such community members who had not been assimilated into Martha's Vineyard culture formed their encapsulated Vineyard communities that, in turn, included or excluded people they viewed as outsiders. Excluded populations included Brazilian immigrants, newcomers, old-guard Vineyarders, and particular individuals or groups of health care providers (e.g., alternative or mainstream health care providers).

Another factor that made Martha's Vineyard an excellent venue was Vineyarders. The insightful data that study participants and other Vineyarders provided, their well-thought out responses to interview questions and their actions described here are significant contributions. Also, Vineyarders led me to significant archival data and directed me toward knowledgeable people to interview. Vineyarders confirmed that ethnography is a valuable tool and that anthropology is a valuable discipline to shed light on the significance of "community" and "values" and ways in which these promoted or impeded access to health care.

This dissertation affirms the value of thick descriptions. Clifford Geertz (1973:6, 7) claimed that ethnographers aim for such description. Whereas a "thin description"

(Ryle 1949) describes actions, one uses “thick description” (Ryle 1949) to explain the significance, meanings, and purposes of actions (Geertz 1973:7). While Geertz’s definition of culture differed from that used in this dissertation, he described the value of his concept of “culture” to interpret meanings and webs of significance. He claimed that:

believing . . . that man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretative one in search of meaning (Geertz 1973:5).

This dissertation affirms that the anthropological concepts and methods used here were effective means to derive thick descriptions. It affirms the use of anthropology to help define sources of our successes and failures and thereby, to provide a more effective starting point in efforts to resolve community threats.

This ethnography has contributed to the discussion of structure and agent priority, an issue that has been controversial in anthropology. It contributes to the ontologically neutral notion that neither structure nor agent is prior or more real. Social structures and agents can be viewed as interlaced within webs of significance. They are best separated for analytical purposes. Values provided guidelines and social structures defined the limits of power within which Vineyarders exerted their free wills. Vineyarders held varying levels of power and acted within the existing structural limitations while they made efforts to promote their communities, maintain the status quo, and enact change. Through their actions, they created, joined, and maintained their Vineyard communities.

Appendix A. Interview Schedule

QUESTIONS FOR ALL RESPONDENTS

1. What is your birth date?
2. In which MV town (and/or off-Island town) do you live?
3. Do you own or rent your current home on MV?
4. How long have you lived in your current home on MV?
5. How long have you lived on MV?
7. What is your occupation or profession?
8. Within which of the following ranges does your yearly income fall?
Less than \$10,000 / \$10,000-14,999 / \$15,000-24,999 / \$25,000-34,999 / \$35,000-49,999 / \$50,000-74,999 / \$75,000-99,999 / \$100,000-149,999 / \$150,000-199,000 / \$200,000+
9. How many children do you have?
10. How many of your children live in your home?
11. What is your marital status?
12. What is your racial identity?
13. What is your ethnic identity?
14. What is your nationality (citizenship)?
15. What is your gender?

16. Which of the following best describes your highest level of education?
Less than 9th grade / 9th to 12th grade, no diploma / Highschool graduate or GED /
Some college, no degree / Associates / Bachelors / Masters / Doctoral /
Professional Degree / Post Doctoral Degree
17. What do you like most about MV?
18. What do you like least about MV?
19. What do you identify as your community on MV?
20. Do you identify a place (or group) other than a place located on MV as the location of your community?
21. What place do you identify as the location of your off-Island community?
22. What do you believe is your most important life achievement?
23. Are you currently employed?
24. By whom are you employed?
25. Are you employed: Regularly, Full/Part-time; Seasonally, Full/Part-time; or Other, please specify?
26. Do you have a disability?
27. Reason currently unemployed?
28. Were you born on MV?
29. Have you lived on MV since the day you were born?
30. Describe your current residency on MV.

FOR SEASONAL RESIDENTS:

36. For how long have you been a seasonal resident of MV?
37. Which generation of your family was first to establish a seasonal residence on MV?
38. What seasons do you spend on MV?

39. Did you visit MV before deciding to live on MV seasonally?
40. Why did you decide to live part-year on and part-year off-Island?
41. Do you plan to become a year-round resident of MV?
42. Do you plan to relocate your seasonal residence elsewhere?
43. Why do you plan to relocate your seasonal residence from MV?
44. To where do you plan to relocate?

FOR YEAR-ROUND RESIDENTS

45. Were you born on MV?
46. Did you live on MV part-time before deciding to live year-round on MV?
47. Why did you chose to make MV your permanent residence.
48. Where did you live before moving to MV?
49. For how long have you been a year-round resident of MV?
50. Which generation of your family was first to establish a year-round residence on MV?
51. Do you plan to relocate elsewhere from MV?
52. Why do you plan to relocate from MV?
53. To where do you plan to relocate?

ALL RESPONDENTS

54. What do you believe are the most significant current event(s) on MV?
55. What do you believe have historically been the most significant event(s) on MV?
56. What do you believe are the most significant current event(s) in the development of health care services on MV?

57. What do you believe are the most significant historical event(s) in the development of health care services on MV?
58. What are the factors consider most important when choosing health care services provided?
59. Do you rate your own health as: excellent, very good, good, fair or poor?
60. How many times a month do you exercise (e.g. jogging, bicycling, swimming, aerobics health club, yoga)?
61. Have you donated time or money to a MV health care organization?
62. To what organization(s) did you donate?
63. What motivated you to make your donation?
64. Do you believe there are too many, enough, or not enough primary care (generalist/family) physicians?
65. Do you believe there are too many, enough, or not enough specialist physicians on MV?
66. Do you have a family, individual, dental, prescription drug or no health insurance plan?
67. How did you obtain your health insurance?
68. What type of health insurance do you have?
69. Do MV health care providers accept your health insurance?
70. Do off-island health care providers accept your health insurance?
71. Is your health insurance adequate, somewhat adequate or not adequate to meet your health care needs?
72. Do you believe all Vineyarders should be able to get health insurance?
73. How should health insurance be provided to all Vineyarders?
74. Do you believe all Vineyarders should be required to get health insurance?

75. Do you believe all Vineyarders should be required to get health insurance?
76. MV health care provider/administrator/trustee or do you hold a political office?

Health care consumers QUESTION 77
Health care practitioners QUESTION 176
Health care trustees QUESTION 313
Health care administrators QUESTION 407
Political office holders QUESTION 507

QUESTIONS FOR HEALTH CARE CONSUMERS

77. While living on MV, did you or a household member experience any major health problem(s)?
78. What kind of health problem did you experience?
79. What kind of health problem did household member experience?
80. While living on MV did you or a household member need health care services?
81. Do you believe there are barriers to or difficulties in getting professional health care services on MV?
82. What do you believe are the most significant barriers to getting health care services on MV?
83. Do you believe barriers to or difficulties in getting health care services are more pronounced, about the same, or less pronounced on MV than in off-Island rural communities?
84. Do you believe that barriers to or difficulties in getting health care on MV have been caused by factors produced on-Island or by factors produced off-Island? (please explain your answer)
85. Do you believe that any of the following have led to barriers to getting health care on MV: federal, Massachusetts, or government health insurance programs such as Medicare?
86. Do you believe that any of the following have led barriers to getting health care on MV: Health care being provided through HMO or non-HMO third party payers? (please explain your answer)

87. Do you believe efforts to remove barriers to getting health care services on MV have been highly effective, effective, somewhat effective, not very effective or not effective at all?
88. Which efforts to remove barriers to or difficulties in getting health care services on MV have been effective?
89. Which efforts to remove barriers/difficulties in getting health care services on MV have not been effective?
90. What do you believe can be done to help remove barriers to or difficulties in getting health care on MV?
91. Did you or a household member have trouble getting healthcare from MV health care providers?
92. Please list each kind of MV health care provider you or your household member encountered problems getting health care.
93. Please explain why you or a household member had trouble getting health care services.
94. Was your health problem(s) resolved even though you did not get these health care services?
95. Did you/household member have trouble getting healthcare from off-Island health care providers while you were on MV?
96. Please list each kind of off-Island health care provider had trouble getting health care
97. Please explain why you or a household member had trouble getting these health care services
98. Were health problem(s) resolved even though did not get these health care services?
99. Do you or member(s) of your household spend less on any of the following because you spend on health care (do not include money spent on health insurance)?
Food / Gas / Heat / Home maintenance / Car maintenance / Enjoyment / Sports and exercise / Things to adorn my home or yard / New addition(s) to my home / Hobbies / Donations to charities / Education / Travel, vacations / Gifts / Medicine/filling prescriptions / All of the above / None of the above / Other
100. Do you have health insurance?

101. Do you believe there have been negative consequences of your having health insurance?
102. What negative consequences have you experienced from having health insurance?
103. Do you or member(s) of your household spend less on any of the following because you spend on health insurance instead? If yes, which of the below?
Food / Gas / Heat / Home maintenance / Car maintenance / Enjoyment / Sports and exercise / Things to adorn my home or yard / New addition(s) to my home / Hobbies / Donations to charities / Education / Travel, vacations / Gifts / Medicine/filling prescriptions / All of the above / None of the above / Other
104. Do you believe that you or member(s) of your household go to health care providers: more often, less often, about the same as if I/household member did not have health insurance?
105. Do you believe that by having health insurance you or member(s) of your household are able to make: more choices, fewer choices (with which I have been satisfied), fewer choices (with which I have not been satisfied), or the same number of choices concerning health care providers?
106. If health is better, worse or about the same as it would be if you did not have health insurance?
107. What has prevented you from getting health insurance?
108. Do you believe there have been negative consequences of your not having health insurance?
109. What negative consequences have you experienced from not having health insurance?
110. Do you believe that you or member(s) of your household go to health care providers: more often, less often, about the same as if I/household member did not have health insurance
111. Do you believe that by not having health insurance you are able to make: more choices, fewer choices (with which I have been satisfied), fewer choices (with which I have not been satisfied), or the same number of choices concerning health care providers?
112. If your health is better, worse or about the same as it would be if you had adequate health insurance?

113. Did you/household contract a long-term or permanent injury or disease because you did not seek health care services when you needed them? If NO, skip to question 116
114. What long-term disease or permanent injury did you receive because you did not seek health care services?
115. What long-term disease or permanent injury did your household member receive because he or she did not seek health care services?
116. Did you/household contract a long-term or permanent injury or disease because refused health care? If NO, skip to question 119
117. What long-term disease or permanent injury did you receive because you were refused health care services?
118. What long-term disease or permanent injury did your household member receive because he or she was refused health care services?
119. Have you or a member(s) of your household ever received a house call from a Vineyard physician?
120. Have you/household ever had past due health care bill from MV or off-Island health care providers? If NO, skip to question 126
121. Was this past due bill ongoing?
122. What methods did health care providers use to get payments?
126. Have MV persons or organizations ever helped you/household member to get health care services? If YES, skip to question 128
127. Which of these best describes why you chose none in response to question 126?
Help was not needed or help needed was not available
128. Please describe way(s) MV person(s) or organization(s) helped you/your household member?
129. Did this help enable you/your household member to get the services needed?
130. Have any off-Island person(s) or organization(s) ever helped you/your household member to get health care services? If YES, skip to question 132

131. Which of these best describes why you chose none in response to question 130?
Help was not needed or help needed was not available

132. Please describe way(s) off-Island person(s) or organization(s) helped you/your household member.

133. Did this help enable you/your household member to get the services needed?

134. A 1998 study found that 19% of Vineyarders had no health insurance (whereas only 7% of Massachusetts residents did not have health insurance). Do you believe anything should be done to enable uninsured MV residents to obtain health care services?

135. What do you believe should be done to enable such uninsured persons to obtain health care services?

136. What kinds of factors do you believe MV voters should consider when voting for candidates for political office?

The following evaluations questions 137-155) may be rated as such: excellent, very good, good, fair, or poor. Please explain your answers:

137. What is your evaluation of performances by Martha's Vineyard Hospital/ER/fast track in meeting the health care needs of Vineyarders?

138. What is your evaluation of performances by Windemere Nursing and Rehabilitation Center in meeting the health care needs of Vineyarders?

139. What is your evaluation of performances by Long Hill (assisted living) in meeting the health care needs of Vineyarders?

140. What is your evaluation of performances by Henrietta Brewer House (assisted living) in meeting the health care needs of Vineyarders?

141. What is your evaluation of performances by MV Community Services in meeting the health care needs of Vineyarders?

142. What is your evaluation of performances by Vineyard Nursing Association in meeting the health care needs of Vineyarders?

143. What is your evaluation of performances by Hospice of Martha's Vineyard in meeting the health care needs of Vineyarders?

144. What is your evaluation of performances by MV physicians in meeting the health care needs of Vineyarders?
145. What is your evaluation of performances by MV chiropractors in meeting the health care needs of Vineyarders?
146. What is your evaluation of performances by MV nursing practitioners in meeting the health care needs of Vineyarders?
147. What is your evaluation of performances by Island Health (the MV rural health clinic) in meeting the health care needs of Vineyarders?
148. What is your evaluation of performances by Vineyard House (Sober House) in meeting the health care needs of Vineyarders?
149. What is your evaluation of performances by MV Family Planning in meeting the health care needs of Vineyarders?
150. What is your evaluation of performances of health care practitioners such as RNs, LPNs, CNAs, Radiologists, Diagnostic Technicians, Medical Technicians in meeting the health care needs of Vineyarders?
151. What is your evaluation of performances by MV alternative health care providers (e.g. acupuncturists, massage therapists) in meeting the health care needs of Vineyarders?
152. What is your evaluation of performances by MV emergency transport services: A. Ambulance B. Medivac (flight) services in meeting the health care needs of Vineyarders?
153. What is your evaluation of performances by non-emergency transport services (e.g. the Lift or rides to Boston health care providers) in meeting the health care needs of Vineyarders?
154. What is your evaluation of performances by off-island health care practitioners in meeting the health care needs of Vineyarders?
155. What is your evaluation of performances by off-island health care organizations that Vineyarders use in meeting the health care needs of Vineyarders?

ORIENTATIONS TO HEALTH CARE FOR US CITIZENS

156. Do you believe adult US citizens who live on MV should be provided health care services regardless of their ability to pay if they are employed:

Full-time

Part-time

Either full-time or part-time

Employment should not be basis for determining who gets health care.

157. Do you believe children of US citizens who live on MV should be provided health care services regardless of their parents' ability to pay if their parents are employed:

Full-time

Part-time

Either full-time or part-time

Employment should not be basis for determining who gets health care.

158. Do you believe adult US citizens who live on MV should be provided health care services regardless of their ability to pay to, if they are unemployed:

Due to being a student

Due to being retired

Due to mobility limitations

Due to self-care limitations

Due to disability

Due to pregnancy

Due to parental responsibilities

Due to it not being the season during which they do seasonal work

Due to other reason, please specify

Regardless of reason for unemployment, health care services should be provided.

Regardless of reason for unemployment, health care services should be provided only if can pay.

159. Do you believe children of US citizens who live on MV should be provided health care services regardless of their parents' ability to pay if their parents are unemployed:

Due to being a student

Due to being retired

Due to mobility limitations

Due to self-care limitations

Due to disability

Due to pregnancy

Due to parental responsibilities

Due to it not being the season during which they do seasonal work

Due to other reason, please specify

Regardless of reason for unemployment, health care services should be provided.

Regardless of reason for unemployment, health care services should be provided only if can pay.

160. Do you believe adult US citizens who live on MV should be provided health care services:

- According to the same rates for all that are established by health care provider
- According to rates health care provider determines on a person by person basis
- According to a sliding-fee based on income
- Only if they can pay for it with insurance or by self-pay
- Regardless of ability to pay
- Other, please specify

161. Do you believe children of US citizens who live on MV should be provided health care services

- According to the same rates for all that are established by health care provider
- According to rates health care provider determines on a person by person basis
- According to a sliding-fee based on their parents' income
- Only if their parents can pay for it with insurance or by self-pay
- Regardless of their parents' ability to pay
- Other, please specify

ORIENTATIONS TO HEALTH CARE FOR NON-US CITIZENS (LEGAL RESIDENCE/EMPLOYMENT)

162. Do you believe adult non citizens living on MV should be provided health care services regardless of their ability to pay if they are legally employed

- Full-time
- Part-time
- Either full-time or part-time
- Employment should not be basis for determining who gets health care.

163. Do you believe children of non citizens living on MV should be provided health care services regardless of their parents' ability to pay if their parents are legally employed:

- Full-time
- Part-time
- Either full-time or part-time
- Employment should not be basis for determining who gets health care.

164. Do you believe adult non citizens who have legal resident status on MV (OR ON USA?) should be provided health care services regardless of ability to pay if they are unemployed:

Due to being a student

Due to being retired

Due to mobility limitations

Due to self-care limitations

Due to disability

Due to pregnancy

Due to parental responsibilities

Due to it not being the season during which they do seasonal work

Due to other reason, please specify

Regardless of reason for unemployment, health care services should be provided.

Regardless of reason for unemployment, health care services should be provided only if can pay.

165. Do you believe children of non citizens who have legal resident status on MV should be provided health care services regardless of their parents' ability to pay and whose parents are unemployed:

Due to being a student

Due to being retired

Due to mobility limitations

Due to self-care limitations

Due to disability

Due to pregnancy

Due to parental responsibilities

Due to it not being the season during which they do seasonal work

Due to other reason, please specify

Regardless of reason for unemployment, health care services should be provided.

166. Do you believe adult non citizens who have legal resident status on MV should be provided health care services:

According to the same rates for all that are established by health care provider

According to rates health care provider determines on a person by person basis

According to a sliding-fee based on income

Only if they can pay for it with insurance or by self-pay

Regardless of ability to pay

Other, please specify

167. Do you believe children of non citizens who have legal resident status on MV should be provided health care services:

- According to the same rates for all that are established by health care provider
- According to rates health care provider determines on a person by person basis
- According to a sliding-fee based on their parents' income
- Only if their parents can pay for it with insurance or by self-pay
- Regardless of their parents' ability to pay
- Other, please specify

ORIENTATIONS TO HEALTH CARE FOR NON-US CITIZENS
(WITHOUT LEGAL RESIDENCE/EMPLOYMENT)

168. Do you believe adult non citizens who live on MV should be provided health care services regardless of ability to pay if they are illegally employed:

- Full-time
- Part-time
- Either full-time or part-time
- Employment should not be basis for determining who gets health care.

169. Do you believe children of non citizens who live on MV should be provided health care services regardless of ability to pay if their parents are not legally employed:

- Full-time
- Part-time
- Either full-time or part-time
- Employment should not be basis for determining who gets health care.

170. Do you believe adult non citizens who do not have legal resident status should be provided health care services regardless of ability to pay if they are unemployed:

- Due to being a student
- Due to being retired
- Due to mobility limitations
- Due to self-care limitations
- Due to disability
- Due to pregnancy
- Due to parental responsibilities
- Due to it not being the season during which they do seasonal work
- Due to other reason, please specify
- Regardless of reason for unemployment, health care services should be provided.
- Regardless of reason for unemployment, health care services should be provided only if can pay.

171. Do you believe children of non citizens who do not have legal resident status should be provided health care services to regardless of their parents' ability to pay if their parents are unemployed:

Due to being a student

Due to being retired

Due to mobility limitations

Due to self-care limitations

Due to disability

Due to pregnancy

Due to parental responsibilities

Due to it not being the season during which they do seasonal work

Due to other reason, please specify

Regardless of reason for unemployment, health care services should be provided.

Regardless of reason for unemployment, health care services should be provided only if can pay.

172. Do you believe adult non citizens who do not have legal resident status should be provided health care services to on MV:

According to the same rates for all that are established by health care provider

According to rates health care provider determines on a person by person basis

According to a sliding-fee based on income

Only if they can pay for it with insurance or by self-pay

Regardless of ability to pay

Other, please specify

173. Do you believe children of non citizens who do not have legal resident status should be provided health care services to on MV:

According to the same rates for all that are established by health care provider

According to rates health care provider determines on a person by person basis

According to a sliding-fee based on their parents' income

Only if their parents can pay for it with insurance or by self-pay

Regardless of their parents' ability to pay

Other, please specify

174. Are there other people with whom you believe I should speak?

175. Is there anything I have not covered that you believe is important?

QUESTIONS FOR HEALTH CARE PRACTITIONERS

176. Are you a MV health care practitioner?

177. What is your health care profession?

IF NOT "MD," SKIP TO 179

178. Are you a board certified physician? If yes, please specify.

179. At which college or university did you do your undergraduate studies?

180. At which college, university or school did you complete your professional studies to become licensed as a health care provider?

181. Are you licensed to practice as a specialist?

IF "NO," SKIP TO QUESTION 184

182. At which institution did you complete your post graduate studies/residencies, practica, or certificate studies to become a licensed specialist?

183. In what specialties are you licensed to practice?

184. What is the highest degree or combination of highest degrees you have earned in health care related disciplines?

186. What motivated you to become a health care practitioner?

187. How did you find out about opportunities to practice health care on MV?

188. Did you know any MV health care practitioners before coming to MV to work as a health care professional?

189. Why did you choose MV as a place to practice health care?

190. What kind(s) of health care experience(s) do you try to provide for your patients?

191. What characteristics of the MV health care system do you consider advantageous?

193. What characteristics of the MV health care system do you consider disadvantageous?

195. What characteristics of MV social life and culture do you consider advantageous?
197. What characteristics of MV social life do you consider disadvantageous?
199. Are you willing to evaluate performances by (other) MV health care providers?

IF “NO” SKIP TO QUESTION 217

The following evaluations (questions 200-216) may be rated as such: excellent, very good, good, fair, or poor; please explain your answers:

200. What is your evaluation of performances by Martha’s Vineyard Hospital/ER/fast track in meeting the health care needs of Vineyarders?
201. What is your evaluation of performances by Windemere Nursing and Rehabilitation Center in meeting the health care needs of Vineyarders?
202. What is your evaluation of performances by Long Hill (located in Edgartown)in meeting the health care needs of Vineyarders?
203. What is your evaluation of performances by Henrietta Brewer House (located in Vineyard Haven) in meeting the health care needs of Vineyarders?
204. What is your evaluation of performances by MV Community Services in meeting the health care needs of Vineyarders? (Island Counseling Center/Visiting Nurse/Disability Services/Early Childhood/Child Care/ Family Daycare/Head Start/Family Networks/Family Center/Residential & Independent Living Supports/Employment Services/Outpatient Mental Health/Daybreak/Diagnostic & Evaluation/Substance Abuse Program/Readjustment Counseling for Veterans/Women’s Support Services).
205. What is your evaluation of performances by MV Vineyard Nursing Association in meeting the health care needs of Vineyarders?
206. What is your evaluation of performances by Hospice of Martha’s Vineyard in meeting the health care needs of Vineyarders?
207. What is your evaluation of performances by MV physicians in meeting the health care needs of Vineyarders?
208. What is your evaluation of performances by MV chiropractors in meeting the health care needs of Vineyarders?

209. What is your evaluation of performances by MV nursing practitioners in meeting the health care needs of Vineyarders?
210. What is your evaluation of performances by Island Health (the MV rural health clinic located next to Stop and Shop Pharmacy, Edgartown) in meeting the health care needs of Vineyarders?
211. What is your evaluation of performances by Vineyard House in meeting the health care needs of Vineyarders?
212. What is your evaluation of performances by MV Family Planning in meeting the health care needs of Vineyarders?
213. What is your evaluation of performances of the following kinds of MV health care practitioners who have provided health care to you, member(s) of your household or your patients in meeting the health care needs of Vineyarders? e.g. RN, LPN, CNA, Radiologist, Diagnostic Technician, Medical Technician
214. What is your evaluation of performances by MV alternative health care providers (e.g. acupuncturists, massage therapists) in meeting the health care needs of Vineyarders?
215. What is your evaluation of performances by MV emergency transport services in meeting the health care needs of Vineyarders? A. Ambulance B. Medivac (flight) services
216. What is your evaluation of performances by non-emergency transport services in meeting the health care needs of Vineyarders (e.g. the Lift or rides to Boston health care providers)?
217. Are you willing to evaluate performances by (other) off-Island health care providers?
218. What is your evaluation of performances by off-island health care practitioners in meeting the health care needs of Vineyarders? (excellent, very good, good, fair, or poor) please explain your answers.
220. Did you work as a health care practitioner before coming to MV?
221. How long have you been in your current position?
Less than 1 year / 1 - 2 years / 3 - 4 years / 5 - 6 years / 7 - 8 years / 9 - 10 years / 11 - 15 years / 16 - 20 years / 21 - 30 years / 31+ years
222. How long have you been a health care practitioner on MV?

223. What year did you become a health care practitioner?

224. Are you aware of any major new developments taking place in your health care profession?

225. What types of payment do you accept for your health care services?

226. Do you provide charitable care for some patients?

IF "NO," SKIP TO QUESTION 228

227. How do people find out that you give charitable care?

228. Have you helped anyone who claimed to be having difficulty getting health care?

IF "NO," SKIP TO QUESTION 230

229. In what ways you have helped health care consumers who claimed to have difficulty getting health care?

230. Can you answer some questions about billing practices?

231. What methods have you or your staff used to get past due payments?

234. Do you believe there are barriers to getting health care services on MV?

IF "NO" OR "DO NOT KNOW," SKIP TO QUESTION 244

235. What do you believe are the most significant barriers to getting health care services on MV?

236. Do you believe barriers to getting health care services are more pronounced, about the same, or less pronounced on MV than in off-Island rural communities?

237. Do you believe that barriers to getting health care on MV have been caused by factors produced on-Island or by factors produced off-Island? (please explain your answer)

238. Do you believe that any of the following have led to barriers to getting health care on MV: federal, Massachusetts, or government health insurance programs such as Medicare? (please explain your answer)

239. Do you believe that any of the following have led barriers to getting health care on MV: Health care being provided through HMO or non-HMO third party payers? (please explain your answer).

240. Do you believe efforts to remove barriers to getting health care services on MV have been highly effective, effective, somewhat effective, not very effective or not effective at all?

241. Which efforts to remove barriers to getting health care services on MV have been effective?

242. Which efforts to remove barriers to getting health care services on MV have not been effective?

243. What do you believe can be done to help remove barriers to getting health care on MV?

244. A 1998 study found that 19% of Vineyarders had no health insurance (whereas only 7% of Massachusetts residents did not have health insurance). Do you believe anything should be done to enable uninsured MV residents to obtain health care services?

IF "NO" SKIP TO QUESTION 246

245. What do you believe should be done to enable such uninsured persons to obtain health care services?

246. What are your roles as a Vineyard health care provider?

247. Which of the following stages most closely describes the level of development of your health care practice:

In its early stages

About halfway to the point at which you would like it to be

Close to full capacity

At full capacity

Other, please specify

248. What kinds of health problems do you treat?

249. What geographical area do you service?

250. What are the primary demographic characteristics of the patients to whom you provide health care?

In what ways do you believe that MV health care conditions are beneficial to:

251a. Health care consumers:

251b. Health care practitioners of your kind:

251c. Physicians:

251d. Health care administrators:

251e. Health care trustees:

In what ways do you believe that MV health care conditions are detrimental to:

252a. Health care consumers:

252b. Health care practitioners of your kind:

252c. Physicians:

252d. Health care administrators:

252e. Health care trustees:

255. Which of the following best describes your work as a health care provider:

Regular full-time

Regular part-time

Regular seasonal

Consultant

Occasional part-time

Occasional seasonal

Other, please specify

256. Are you a non-physician health care provider?

IF YES, SKIP TO QUESTION 299

QUESTIONS FOR PHYSICIANS

257. Do you make house calls?

IF "NO," SKIP TO QUESTION 260

258. How many hours per month do you spend on house calls?

259. How do you organize your house calls?

260. Do you currently have a contract with MVH?

IF NO, SKIP TO QUESTION 270

261. Which most closely describes your contractual relationship with MVH?

- a. MVH serves as an integrated delivery hub; I am employee of MVH or its affiliated clinics
- b. MVH has hospital-based medical practices that are managed and owned fully or in part by hospital; I am employee of MVH medical practice or department
- c. I am a locum tenens who is employed by an agency to work from a few weeks to several months at MVH
- e. Other, please specify

262. What is your status at MVH? (e.g., independent contractor, employee, shareholder)

263. What type of work do you do at MVH? (e.g., administrative, clinical, surgical)

264. Do you have hospital privileges at MVH?

IF "NO" SKIP TO QUESTION 267

265. What do you do in return for hospital privileges at MVH?

266. What do you receive in return for hospital privileges at MVH?

267. To which organization(s) or individual(s) do you refer your MVH patients?

268. Are there any major new developments taking place at MVH? (Please explain your answer).

269a. How do you rate the ease with which MVH is able to recruit and retain physicians?

- a. Not easy
- b. Somewhat easy
- c. Easy
- d. Very easy

269b. Why did you rate MVH's ease recruiting and retaining health care personnel as such?

270. Do you currently have a contract with an off-Island hospital?

IF NO, SKIP TO QUESTION 281

271. Which most closely describes your contractual relations with the off-Island hospital?

- a. Off-Island serves as an integrated delivery hub; I am employee of off-Island hospital or its affiliated clinics
- b. Off-Island has hospital-based medical practices that are managed and owned fully or in part by hospital; I am employee of off-Island hospital medical practice or department
- c. I am a locum tenens who is employed by an agency to work from a few weeks to several months at off-Island hospital
- d. Other, please specify

272. What is your status at the off-Island hospital? (e.g., independent contractor, employee, shareholder)

273. What type of work do you do at the off-Island hospital? (e.g., administrative, clinical, surgical)

274. Do you have hospital privileges at an off-island hospital(s)?

IF "NO" SKIP TO QUESTION 278

275. At which off-Island hospital(s)?

276. What do you do in return for hospital privileges at the off-Island hospital(s)?

277. What do you receive in return for hospital privileges at the off-Island hospital(s)?

278. To which organization(s) or individual(s) do you refer your MV patients at your off-Island hospital?

279. Are there any major new developments taking place at your off-Island hospital?

280. How do you rate the ease with which your off-Island hospital is able to recruit and retain physicians? a. Not easy b. Somewhat easy c. Easy d. Very easy

280b. Why did you rate your off-Island hospital's ease recruiting and retaining health care personnel as such?

281. Do you currently have your own or are you a partner or an employee of a group medical practice on MV?

IF "NO," SKIP TO QUESTION 288

282. What kind of medical practice do you have on MV? (E.g., solo or group practice, employee)

283. What is your status at your MV medical practice? (e.g., independent contractor, employee, shareholder)

284. What type of work do you do at your MV medical practice? (e.g., administrative, clinical, surgical)

285. To which organization(s) or individual(s) do you refer patients at your MV medical practice?

286. Are any major new developments taking place in your MV medical practice (please explain your answer).

287a. How do you rate the ease with which your MV medical practice is able to recruit and retain physicians? a. Not easy b. Somewhat easy c. Easy d. Very easy

287b. Why did you rate your MV medical practice's ease recruiting and retaining health care personnel as such?

288. Do you currently have your own or are you a partner or an employee of a group medical practice off-Island?

IF "NO," SKIP TO QUESTION 295

289. What kind of medical practice do you have off-Island? (E.g., solo or group practice, employee)

290. What is your status at your off-Island medical practice? (e.g., independent contractor, employee, shareholder)

291. What type of work do you do at your off-Island medical practice? (e.g., administrative, clinical, surgical)

292. To which organization(s) or individual(s) do you refer your MV patients at your off-island medical practice?

293. Are any major new developments taking place in your off-Island medical practice

294a. How do you rate the ease with which your off-Island medical practice is able to and retain physicians? a. Not easy b. Somewhat easy c. Easy d. Very easy

294b. Why did you rate your off-Island medical practice's ease recruiting and retaining health care personnel as such?

295. Do you currently have contractual relations with one or more insurance company(s)?

IF NO, PLEASE SKIP TO QUESTION 311

296. What kind of contractual relations do you have with insurance company(s)? (e.g., fee for service, salaried, capitation, part of network-model HMO)

297. What do you do in exchange for these contractual relations

298. How do you expect these contractual relations to met your goals?

FOR NON-PHYSICIAN HEALTH CARE PROVIDERS

299. Are you currently employed by a MV health care organization?

IF NO, SKIP TO QUESTION 305

300. By which MV health care organization are you currently employed?

301. What is your status at the MV health care organization by which you are employed? (e.g., independent contractor, employee, shareholder)

302. What type of work do you do at the MV organization by which you are employed? e.g., administrative, clinical, consultation)

303. Are there any major new developments taking place at the MV organization by which you are employed?

304a. How do you rate the ease with which the MV organization by which you are employed is able to recruit and retain health care providers

a. Not easy b. Somewhat easy c. Easy d. Very easy

304b. Why did you rate your health care organization's ease recruiting and retaining health care personnel as such?

305. Are you currently employed by an off-Island health care organization?

IF NO, SKIP TO QUESTION 311

306. By which off-Island health care organization are you currently employed?

307. What is your status at the off-Island health care organization by which you are employed? (e.g., independent contractor, employee, shareholder)

308. What type of work do you do at the off-Island organization by which you are employed? (e.g., administrative, clinical, surgical)

309. Are there any major new developments taking place at the off-Island organization by which you are employed?

310a. How do you rate the ease with which the off-Island organization by which you are employed is able to recruit and retain health care providers?

a. Not easy b. Somewhat easy c. Easy d. Very easy

310b. Why did you rate your off-Island health care organization's ease recruiting and retaining health care personnel as such?

311. Are there other people with whom you believe I should speak?

312. Is there anything I have not covered that you believe is important?

QUESTIONS FOR HEALTH CARE TRUSTEES

313. Are you currently a trustee for a MV health care organization?

IF "NO," SKIP TO QUESTION 315

315. Are you currently a health care trustee for an off-Island health care organization(s)?

IF "NO," SKIP TO QUESTION 318

316. For which off-Island health care organization(s) are you a trustee?

317. In what town is it located?

318. Have you ever served as a trustee for any other organization(s)?

IF "NO," SKIP TO QUESTION 320

319. Which one(s)?

320. What is the title of your current trustee position(s)?

321. What type of trustee work do you do within your MV health care organization?

322. What are the missions or goals of your MV health care organization?

323. What kinds of health care services does your MV health care organization(s) provide?

324. What kinds of health problems does your MV health care organization treat?

325. What geographical area does your MV health care organization service?

326. What are the primary demographic characteristics of the patients to whom your MV health care organization provides health care?

In what ways do you believe that MV health care conditions are beneficial to:

327a. Health care consumers:

327b. Physicians:

327c. Health care administrators:

327d. Health care trustees:

In what ways do you believe that MV health care conditions are detrimental to:

328a. Health care consumers:

328b. Physicians:

328c. Health care administrators:

328d. Health care trustees:

332. Why was your health care organization created?

334. Why did you choose to become a trustee for a MV health care organization?
335. For how long have you been a health care trustee on MV?
336. What kind of health care experience(s) does your organization try to provide for its patients?
337. Do you believe there are barriers to getting professional health care services on MV?

IF “NO” OR “DO NOT KNOW,” SKIP TO QUESTION 347

338. What do you believe are the most significant barriers to getting health care services on MV?
339. Do you believe barriers to getting health care services are more pronounced, about the same, or less pronounced on MV than in off-Island rural communities?
340. Do you believe that barriers to getting health care on MV have been caused by factors produced on-Island or by factors produced off-Island? (please explain your answer)
341. Do you believe that any of the following have led to barriers to getting health care on MV: federal, Massachusetts, or government health insurance programs such as Medicare? (please explain your answer)
342. Do you believe that any of the following have led barriers to getting health care on MV: Health care being provided through HMO or non-HMO third party payers? (please explain your answer).
343. Do you believe efforts to remove barriers to getting health care services on MV have been highly effective, effective, somewhat effective, not very effective or not effective at all?

IF “d,” SKIP TO QUESTION 345

IF “e,” SKIP TO QUESTION 346

344. Which efforts to remove barriers to getting health care services on MV have been effective?
345. Which efforts to remove barriers to getting health care services on MV have not been effective?

346. What do you believe can be done to help remove barriers to getting health care on MV?

347. What characteristics of the MV health care system have you found to be advantageous to your performance as a trustee?

348. What characteristics of the MV health care system have you found to be disadvantageous to your performance as a trustee?

349. What has your health care organization(s) done to adapt to current MV health care conditions?

350. What has your MV health care organization(s) done to adapt to current health care laws?

351. Which of the following stages most closely describes the level of development of your health care organization:

In its early stages

About halfway to the point at which you would like it to be

Close to full capacity

At full capacity

Other, please specify

352. In what ways (if any) does your health care organization cooperate with other MV health care organizations?

IF "NONE," SKIP TO QUESTION 356

353. With which kinds of MV health care organizations does your health care organization cooperate?

354. What is your health care organization's goals when cooperating with these MV health care organizations?

355. How have you participated in this cooperation?

356. In what ways (if any) does your health care organization cooperate with any off-Island health care organizations?

IF "NONE," SKIP TO QUESTION 360

357. With which kinds of off-Island health care organizations does your health care organization cooperate?

358. What is your health care organization's goals when cooperating with these off-Island health care organizations?

359. How have you participated in this cooperation?

368. In what ways (if any) does your health care organization compete with any MV health care organizations?

IF "NONE," SKIP TO QUESTION 372

369. With which kinds of MV health care organizations does your health care organization compete?

370. What is your health care organization's goals when competing with these MV health care organizations?

371. How have you participated in this competition?

372. In what ways (if any) does your health care organization compete with any off-Island health care organizations?

IF "NONE," SKIP TO QUESTION 376

373. With which kinds of off-Island health care organizations does your health care organization compete?

374. What is your health care organization's goals when competing with these off-Island health care organizations?

375. How have you participated in this competition?

384. Are you a health care trustee for MVH?

IF NO, SKIP TO QUESTION 386

385. How does MVH prevent competition between MVH and MVH physicians who also have their own practices separate from MVH?

386. In what ways has your health care organization has helped health care consumers who were having difficulty getting health care?

387. Does your health care organization provide charitable care for some patients?

IF “NO,” SKIP TO QUESTION 389

388. How do people find out that your health care organization gives charitable care?

389. What methods have you or your staff used to get past due payments?

392. What are your roles as a Vineyard health care trustee?

393. To which organization(s) or individual(s) does your health care organization refer patients?

394. Do you believe there are too many, enough, or not enough primary care (generalist/family) physicians on MV?

395. Do you believe there are too many, enough, or not enough specialist physicians on MV?

396. What do you believe are the key factors that attract trustees to your health care organization(s)?

397. What issues/challenges does your health care organization(s) face?

398. What kinds of factors does your health care organization consider when hiring staff?

399. How do you rate the ease with which your health care organization is able to recruit and retain health care personnel?

a. Not easy b. Somewhat easy c. Easy d. Very easy

400. Why did you rate your health care organization’s ease recruiting and retaining health care personnel as such?

401. Please describe your accomplishments within your health care organization(s)

402. Are any major new developments taking place in your health care organization? (Please explain your answer).

405. Are there other people with whom you think I should speak?

406. Is there anything I have not covered that you think is important?

QUESTIONS FOR HEALTH CARE ADMINISTRATORS

407. Are you currently an administrator for a MV health care organization?

IF "NO," SKIP TO QUESTION 409

408. For which MV health care organization(s) are you an administrator?

409. Are you currently a health care administrator for an off-Island health care organization(s)?

IF "NO," SKIP TO QUESTION 412

410. For which off-Island health care organization(s) are you an administrator?

411. In what town is it located?

412. Have you ever worked as an administrator for any other health care organization(s)?

IF "NO," SKIP TO QUESTION 414

413. Which one(s)?

414. Which of the following best describes your employment at the health care organization(s) for which you are employed?

- Regular full-time
- Regular part-time
- Regular seasonal
- Consultant
- Occasional part-time
- Occasional seasonal
- Other, please specify

415. What is the title of your administrative position(s)?

416. What type of administrative work do you do within your MV health care organization?

417. What are the missions or goals of your MV health care organization?

418. What kinds of services does your MV health care organization(s) provide?

419. What kinds of health problems does your organization treat?

420. What geographical area does your organization service?

421. What are the primary demographic characteristics of the patients to whom your organization provides health care?

In what ways do you believe that MV health care conditions are beneficial to:

422a. Health care consumers:

422b. Physicians:

422c. Health care administrators:

422d. Health care trustees:

In what ways do you believe that MV health care conditions are detrimental to:

423a. Health care consumers:

423b. Physicians:

423c. Health care administrators:

423d. Health care trustees:

427. Why was your health care organization created?

428. Why was your health care organization located on MV?

429. Why did you choose to become an administrator for a MV health care organization?

430. For how long have you been a health care administrator on MV?

431. What kind of health care experience(s) does your organization try to provide for its patients?

432. Do you believe there are barriers to getting professional health care services on MV?

IF "NO" OR "DO NOT KNOW," SKIP TO QUESTION 442

433. What do you believe are the most significant barriers to getting health care services on MV?

434. Do you believe barriers to getting health care services are more pronounced, about the same, or less pronounced on MV than in off-Island rural communities?

435. Do you believe that barriers to getting health care on MV have been caused by factors produced on-Island or have been caused by factors produced off-Island? (please explain your answer).

436. Do you believe that any of the following have led to barriers to getting health care on MV: federal, Massachusetts, or government health insurance programs such as Medicare? (please explain your answer)

437. Do you believe that any of the following have led barriers to getting health care on MV: Health care being provided through HMO or non-HMO third party payers? (please explain your answer)

438. Do you believe efforts to remove barriers to getting health care services on MV have been highly effective, effective, somewhat effective, not very effective or not effective at all?

IF “d,” SKIP TO QUESTION 440

IF “e,” SKIP TO QUESTION 441

439. Which efforts to remove barriers to getting health care services on MV have been effective?

440. Which efforts to remove barriers to getting health care services on MV have not been effective?

441. What do you believe can be done to help remove barriers to getting health care on MV?

442. What characteristics of the MV health care system have you found to be advantageous to your performance as an administrator?

443. What characteristics of the MV health care system have you found to be disadvantageous to your performance as an administrator?

444. What has your health care organization(s) done to adapt to current MV health care conditions?

445. What has your MV health care organization(s) done to adapt to current health care laws?

446. Which of the following stages most closely describes the level of development of your health care organization:

In its early stages

About halfway to the point at which you would like it to be

Close to full capacity

At full capacity

Other, please specify

447. In what ways (if any) does your health care organization cooperate with any other MV health care organizations?

IF "NONE," SKIP TO QUESTION 451

448. With which kinds of MV health care organizations does your health care organization cooperate?

449. What is your health care organization's goals when cooperating with these MV health care organizations?

450. How have you participated in this cooperation?

451. In what ways (if any) does your health care organization cooperate with any off-Island health care organizations?

IF "NONE," SKIP TO QUESTION 455

452. With which kinds of off-Island health care organizations does your health care organization cooperate?

453. What is your health care organization's goals when cooperating with these off-Island health care organizations?

454. How have you participated in this cooperation?

463. In what ways (if any) does your health care organization compete with any MV health care organizations?

IF "NONE," SKIP TO QUESTION 467

464. With which kinds of MV health care organizations does your health care organization compete?

465. What is your health care organization's goals when competing with these MV health care organizations?

466. How have you participated in this competition?

467. In what ways (if any) does your health care organization compete with any off-Island health care organizations?

IF "NONE," SKIP TO QUESTION 471

468. With which kinds of off-Island health care organizations does your health care organization compete?

469. What is your health care organization's goals when competing with these off-Island health care organizations?

470. How have you participated in this competition?

479. Are you a health care administrator for MVH?

IF NO, SKIP TO QUESTION 481

480. How does MVH prevent competition between MVH and MVH physicians who also have their own practices separate from MVH?

481. Does your health care organization make house calls?

IF "NO," SKIP TO QUESTION 484

482. IF YES: how many hours per week does your health care organization spend on house calls?

483. How does your health care organization organize its house calls?

484. What types of payment does your health care organization accept for health care services?

485. What types of insurance does your health care organization accept as payment for its health care services?

486. In what ways has your health care organization has helped health care consumers who were having difficulty getting health care?

487. Does your health care organization provide charitable care for some patients?

IF “NO,” SKIP TO QUESTION 489

488. How do people find out that your health care organization gives charitable care?

489. What methods have you or your staff used to get past due payments?

492. What are your roles as a Vineyard health care administrator?

493. To which organization(s) or individual(s) does your health care organization refer patients?

494. Do you believe there are too many, enough, or not enough primary care (generalist/family) physicians on MV?

495. Do you believe there are too many, enough, or not enough specialist physicians on MV?

496. What do you believe are the key factors that attract administrators to your health care organizations?

497. What issues/challenges does your health care organization(s) face?

498. What kinds of factors does your health care organization consider when hiring staff?

499. How do you rate the ease with which your health care organization is able to recruit and retain health care personnel?

a. Not easy b. Somewhat easy c. Easy d. Very easy

500. Why did you rate your health care organization’s ease recruiting and retaining health care personnel as such?

501. Please describe your accomplishments within your health care organization(s)

502. Are any major new developments taking place in your health care organization? (Please explain your answer).

505. Are there other people with whom you think I should speak?

506. Is there anything I have not covered that you think is important?

QUESTIONS TO THOSE WHO HOLD POLITICAL OFFICE

507. Do you currently hold a political position(s)?
508. What political office(s) do you hold? (List each one and answer questions re: each one)
509. At which level? (E.g., town, region, county of, congressional district, state, US)
510. Is your current political position(s) an elected position or are you appointed or employed?
511. Have you previously held political offices?
- IF "NO," SKIP TO QUESTION 514
512. At which level? (E.g., town, region, county of, congressional district, state, US)
513. Was your former political position an elected position or were you appointed or employed?
514. What are your long-term goals?
515. What are your short-term goals?
516. What characteristics of the MV political system have you found to be advantageous to constituents?
517. What characteristics of the MV political system have you found to be advantageous to those who hold political office?
518. What characteristics of the MV political system have you found to be disadvantageous to constituents?
519. What characteristics of the MV political system have you found to be disadvantageous to those who hold political office?
520. What are your roles as a Vineyard political office holder?
521. Why did you choose to hold political office on MV?
522. What role(s) do members who hold your political office play in determining health care policy on MV?

523. How have you participated in determining health care policy?

524. What role(s) do members who hold your political office play in determining health care access on MV?

525. How have you participated in determining health care access on MV?

526. In what ways (if any) do you cooperate with those who hold other political offices on MV?

IF "NONE," SKIP TO QUESTION 530

527. With which kinds of MV political office holders do you cooperate?

528. What are your goals when cooperating with these political office holders?

529. How have you participated in this cooperation?

530. In what ways (if any) do you cooperate with those who hold off-Island political offices?

IF "NONE," SKIP TO QUESTION 534

531. With which kinds of off-Island political office holders do you cooperate?

532. What are your goals when cooperating with these political office holders?

533. How have you participated in this cooperation?

534. In what ways (if any) do you compete with those who hold other political offices on MV?

IF "NONE," SKIP TO QUESTION 538

535. With which kinds of MV political office holders do you compete?

536. What are your goals when competing with these political office holders?

537. How have you participated in this competition?

538. In what ways (if any) do you compete with those who hold off-Island political offices?

IF “NONE,” SKIP TO QUESTION 542

539. With which kinds of off-Island political office holders do you compete?

540. What are your goals when competing with these political office holders?

541. How have you participated in this competition?

542. What kinds of factors do you believe MV voters should consider when voting for candidates who hold political office?

543. Do you believe there are barriers to getting professional health care services on MV?

IF “NO” SKIP TO QUESTION 549

IF “DO NOT KNOW,” SKIP TO QUESTION 553

544. What do you believe are the most significant barriers to getting health care services on MV?

545. Do you believe barriers to getting health care services are more pronounced, about the same, or less pronounced on MV than in off-Island rural communities?

546. Do you believe that barriers to getting health care on MV have been caused by factors produced on-Island or by factors produced off-Island? (please explain your answer)

547. Do you believe that any of the following have led to barriers to getting health care on MV: federal, Massachusetts, or government health insurance programs such as Medicare? (please explain your answer)

548. Do you believe that any of the following have led barriers to getting health care on MV: Health care being provided through HMO or non-HMO third party payers? (please explain your answer)

549. Do you believe efforts to remove barriers to getting health care services on MV have been highly effective, effective, somewhat effective, not very effective or not effective at all?

IF “NO,” SKIP TO QUESTION 551

IF “DO NOT KNOW,” SKIP TO QUESTION 552

550. Which efforts to remove barriers to getting health care services on MV have been effective?

551. Which efforts to remove barriers to getting health care services on MV have not been effective?

552. What do you believe can be done to help remove barriers to getting health care on MV?

553. Are there other people with whom you think I should speak?

554. Is there anything I have not covered that you think is important?

THANK YOU FOR PARTICIPATING IN THIS INTERVIEW.

Appendix B. Glossary

Advanced Practice Nurses: treat relatively routine ailments, deliver neonates during uncomplicated births; hold a master's degree at minimum.

Adverse selection: from insurers' perspective, unhealthy and at-risk populations are apt to be interested in buying insurance, while the young and healthy tend to be disinterested.

Affordable housing: housing that costs no more per year than one-third of the annual household income.

Altruistic utilitarians: those who suffer as a result of their actions on behalf of others or who pay the costs on behalf of a collective.

American Medical Association: physician professional organization.

Bankruptcy: a petition filed in a federal court asking for protection from creditors wherein the court assumes legal control of the debtor's assets and ends all collection efforts.

Barrier: a material such as a highway or some other structure that prevents action or a nonmaterial entity such as behavioral barriers or trade barriers (Merriam-Webster's Dictionary n.d.a).

Business values: promote a system that promotes health care scarcities and concerns over who would pay for health care or over who would assume financial risks (Stein 1998:81-82, 85-86) (roughly, as opposed to health care values).

Capitation: insurance plan that pays physician per patient enrolled irrespective of how much or how little health care services cost for patients enrolled.

Case mix: percentages of patients grouped according to how well their insurers reimburse health care providers.

Certified nursing assistant (CNA): health care professionals who help transfer immobile patients from bed to a chair, assist the patient with active daily living tasks (e.g., grooming, bathing, dressing, helping to the toilet), and inform the nurse in charge of changes in a patient's status.

Cherry picking: a form of health care rationing that enables insurers to attract clients who tend to be healthy and tend to have low occupational risks, hence are expected to use health care services infrequently.

Clinician: health care practitioner or one who provides hands-on health care (e.g., medical doctors, therapists, nurses, and nursing assistants).

Collective conscience: Durkheim held that a “collective conscience” (or a collective consciousness) is beliefs and values held in common that promote standards of behavior and maintenance of social order (Elwell 2013:273).

Collectivistic utilitarians: those whose actions benefit the collectivity or larger group.

Collectivity: an order of individuals “who have a sense of solidarity by virtue of sharing common values” (Merton 1968:353).

Community: a symbolically constructed system of values, norms, and moral codes (Hamilton 1985:9) that inheres in community member thought and that provides community members with a shared sense of identity (Hamilton 1985:9; Cohen 1985:98).

Community rating: risk spreading wherein health insurance premiums are pooled and insurers pay catastrophic medical costs with premiums obtained from those who seldom use their insurance (Madison 2005:59, 61; Hoffman 2010:11) (as opposed to experience rating).

Concierge medicine: general or family medical practices whose patients pay a fee to join. In exchange for that fee and what the physician charges for visits, patients can receive same day medical appointments, longer office visits than non-concierge physicians, easier access to physicians (by way of impromptu house calls and telephone access) and more oversight.

Co-payment: an amount set by insurers that an insured pays to the health care provider at each visit.

Corporation: a “group, . . . collectivity, or . . . association of individuals joined by a common purpose and often endowed with special rights or privileges” (Robinson 1999:13-14).

Critical access hospital (CAH) designation: must be located in a rural area; provide emergency services 24-hours a day, seven days a week; have 25 beds or fewer; have patients whose length of stay for acute care is 96 hours or less (on average) to be designated as such (Centers for Medicare and Medicaid Services 2014:2).

CT scan (computerized tomograph scan): cross-sectional (slices) of X-ray images of bones, blood vessels and soft tissues taken from different angles and processed by computer to create three dimensional images.

Cultural encapsulation: that which occurs when large influxes of newcomers who are not assimilated into traditional culture exclude those who are assimilated (Newby 1980:259).

Cultural ethos: “the predominant ideas, values, and ideals of a culture or subculture which give it its distinctive character” (Theodorson and Theodorson 1969:93).

Cultural longhand: a more in depth view that tends to be used when insiders express their personal identities among themselves and their “degrees of belonging” (Phillips 1986:144, 149).

Cultural shorthand: a more superficial view when group members represent themselves as a homogeneous and unified group; a dichotomous distinction when viewing one’s group and outsiders (Phillips 1986:144, 149).

Culture: “the community as experienced by its members” (Cohen 1985:98).

Deductible: a set amount set by the insurer that one must pay annually for health care services before one’s insurer begins to pay for his health care.

Difficulty: a lack of resources such as money or ability to interpret; someone objecting to another’s intended action; or embarrassment or trouble that impedes one from performing a desired action (Merriam-Webster's Dictionary n.d.b).

Dukes County Health Council: a 32-member community organization of health care professionals and health care consumers formed to promote cooperation among health care professionals in an effort to improve Martha’s Vineyard’s delivery of health care.

Egoistic utilitarians: Those whose actions suggest they are self-motivated. Egoistic utilitarians believe that the means which are of greatest utility are those means which bring happiness or well-being to the individual or smaller group. Their individual goals motivate their actions.

Emic: from the perspective of those being studied.

Etic: from the perspective of the researcher.

Exchange values: that which an owner receives when exchanging a product or service for something else. That which holds high exchange value can be sold for a large amount whether or not it is useful.

Experience rating: health insurance premiums priced on the basis of actuarial risks grouped according to factors such as policyholder age, geographic location, and size of insurance pool (large or small group or individual) (Madison 2005:59, 61; Hoffman 2010:12-13, 59, 65) (as opposed to community rating).

Exploitative utilitarians: those whose individual goals hold priority while their actions harm or diminish others or undermine the greater good or community well-being.

Gross domestic product: the total value of everything produced by all individuals and companies in an area.

Group: an order of individuals that may or may not share common values.

Health care administrator: health care professionals who are not health care clinicians but rather, run the business aspects of health care organizations.

Health care organization: a business or voluntary organization whose purpose has to do with health care.

Health care power brokers: health care policymakers (corporate and government) who significantly influence health care laws, policies, and abilities to access health care.

Health care practitioners: clinicians or those who provide hands-on health care (e.g., physicians, nurses, therapists, nursing assistants).

Health care professionals: health care practitioners, health care administrators, and health care trustees (abbreviated as HCPTAs in tables).

Health care provider: a single or group of health care professionals (clinicians), one or more health care organizations or both health care professionals and health care organizations.

Health care rationing: withholding health care services, promoting physicians to provide fewer interventions for their patients, discouraging health care consumers from entering the health care system implicitly (furtively) or explicitly.

Health care trustee: nonprofit health care organization board member.

Health care values: health care that is not “managed” and the provision of optimum health care on behalf of the patient (and the community) without regard to the health care organization’s financial interests (Stein 1998:81, 85-86) (roughly, as opposed to business values).

Health insurance: public or private and indemnity or managed care insurers who pay health care costs of beneficiaries as stipulated in contracts.

Home health aide: those who transfer immobile home care patients from bed to a chair; assist the patient with active daily living tasks (e.g., grooming, bathing, dressing, toileting); and inform the nurse in charge of changes in a patient's status.

Homeostasis: a normal stability gained and maintained by coordinated responses of systems that adapt to changes, such as an organism adapting to an environment or a social group adapting to the loss of members or gain of new members (Webster's New World College Dictionary 2014:696).

Horizontal integration: merging of two or more companies that produce or sell the same kinds of products or services.

Hospice of Martha's Vineyard (Hospice): helps terminally ill patients and their family members to cope with dying and grief.

Indemnity insurance: a contractual agreement between an insurer and an insured wherein the insurer agrees to pay the insured for a loss (in the case of health insurance, such a loss would ensue from medical expenses).

Individual mandate: health insurance that mandates individual persons obtain health insurance or employers provide health insurance to their employees.

Invidious comparison: "a process of valuation of persons in respect of worth" (Veblen 1994:34).

Input: something that is transferred to the organization that receives it.

Institution: patterns of social activity expected of individuals or groups.

International Classification of Diseases (ICD): diagnostic coding used in health care billing (see medical coding).

Job-lock: occurs if one is reluctant to change jobs for fear that it would be difficult to obtain health insurance through a new employer (Enthoven 2007:107; Stoll and Baily 2009:10-11 citing *Business Week* 2007 and Madrian 1994).

Level 1 trauma: the most serious trauma as measured by breathing, circulation, central nervous system status, mechanism of injury, and other criteria (Vanderbilt University Medical Center n.d.).

Managed care: health insurance that involves the insurer sharing risk with health care providers through payment schemes such as capitation (where physician is paid same amount per patient enrolled irrespective of how often health care services are used) or by providing or withholding bonuses on the basis of care expenditures physicians generate.

Martha's Vineyard society: all of Martha's Vineyard's communities (or Martha's Vineyard overall).

Massachusetts General Hospital: a teaching affiliate of Harvard Medical School located in Boston.

Medicaid: joint federal and state program that covers medical costs, nursing home care, and personal care services for some people with limited resources.

Medical coding: the International Classification of Diseases system of diagnostic codes health care professionals use to process insurance reimbursement claims.

Medicare: Medicare Part A is a hospital insurance plan paid for by payroll taxes that covers hospital stays, nursing care, skilled nursing care after a hospital stay, some home health services, and hospice care; Medicare Part B is insurance that covers physician services, hospital outpatient services, laboratory and radiological tests, preventive care, durable medical equipment, home health, and ambulance services in exchange for a monthly premium; Medicare Part D is a public insurance program that provides some Americans subsidies to pay for prescription medications.

National health insurance: health insurance programs paid for by the federal government. They may or may not provide public benefits to all citizens.

Nursing assistant: see certified nursing assistant.

Official: owner, employee or volunteer of an organization. Officials can act or speak on behalf of the organization he represents.

Output: something that is transferred elsewhere or is discarded.

Partners: a large hospital and physician network located in the Greater Boston area. Its subsidiaries include seven hospitals (including Martha's Vineyard Hospital and Massachusetts General Hospital), three rehabilitation hospitals, out-patient clinics, skilled nursing facilities, and a large visiting nurse agency.

Partners-employed: employees of a Partners organization located in Boston as opposed to an MVH employee (though Partners owns MVH).

Planetree: a patient-friendly and employee-friendly model of health care that improves the delivery of health care.

Political technology: a policy, word, or metaphor used as “an instrument of power for shaping individuals” (Shore and Wright 2005:4 citing Dreyfus and Rabinow 1982; Dreyfus and Rabinow 1983:134).

Power broker: a policymaker (corporate and government) who significantly influences laws and policies.

Primary health care: the first point of patient contact with the health care system made up of freestanding and employed group or solo physicians, advanced practice nurse practices, emergency department services and clinics that may provide health care at reduced cost, that on Martha’s Vineyard include Family Planning of Martha’s Vineyard, Island Health Care, and Wampanoag Tribal Health Services.

Purging: insurer practice of dumping a small business whose employees’ medical claims exceed that which insurance underwriters had predicted.

Reduced Fee Health Care program: helps some Vineyarders who do not qualify for government programs to obtain health care from general practice and specialist physicians who provide their services at discounted rates.

Rescission: cancellation of a health insurance policy. Insurers review one’s application (typically after one is diagnosed with a costly disease) for an error to legitimate canceling it.

Romneycare: individual mandate health insurance legislation for Massachusetts residents that required employers that employed eleven or more employees to be responsible for subsidizing their employees’ health insurance and uninsured individuals who were not eligible for employer-sponsored health insurance to purchase health insurance.

Safety-net hospital: a public or nonprofit hospital or community clinic that provides emergency, primary and chronic mental health care to the uninsured and others who have difficulty accessing health care (National Association of Public Hospitals and Health Systems n.d.:1; Nardin, Himmelstein, and Woolhandler 2009:2).

Society: an order of individuals who may but do not necessarily have a sense of solidarity; their being part of a particular group is not on the basis of their sharing of common values.

Steamship Authority (SSA): fleet of nine ferries that provide service to Martha's Vineyard (and Nantucket) signed into existence by the Massachusetts governor in 1948 (Ashe 2013a:9). Host communities pay (by tax assessment) SSA deficits if occur (Ashe 2013a:9).

Swing bed: serves either as a hospital bed or as a rehabilitation bed for patients who need rehabilitation therapy services, daily wound care, or training to care for oneself at home (e.g., diabetic care, ostomy care) (Martha's Vineyard Hospital 2009:15).

Thick description: explains the significance, meanings, and purposes of actions (Geertz 1973:7).

Thin description: description of actions (Geertz 1973:7).

Under-insured: insured by high deductible health insurance or health insurance in which the policyholder is responsible for a large percentage of health care costs.

Utilitarian values: those values that promote adherents to act on the basis of that which is expected to bring the most happiness (qualitatively or quantitatively) or well-being to either one self or the larger collectivity or group.

Values: "culturally defined standards" (Elwell 2013:338) that provide general guidelines about what is good, bad, desirable, beautiful or proper (Elwell 2013:338).

Vertical integration: vertically formed networks that occur "between organizations operating in different segments of the same industry" (Wellever 2004:227 citing Pointer, Begun, and Luke 1988).

Visiting nurse organizations: provide short term rehabilitative, long term disability and chronic illness care in patients' homes for those with, for example, AIDS, cardiac issues, Lyme disease or disabilities.

Vineyarders: for Vineyarders, a "Vineyarder" denotes a local—one who lives on Martha's Vineyard. In this dissertation, a "Vineyarder" is one who lived on or visited Martha's Vineyard during the time my field research was being conducted. Vineyarders also include those who lived on or visited Martha's Vineyard during historical periods of time being discussed.

Vineyard shuffle: migrating from one to another Martha's Vineyard home twice each year to avoid steep increases in rent each summer.

Wampanoag Tribal Health Services: federal program of primary physician health care services for the Vineyard Wampanoag.

Wedlock: occurs if one is reluctant to end a bad marriage for fear that it would be difficult to purchase comparable health insurance to that the spouse provided (Enthoven 2007:107).

Well-being: “the accomplishment of socially reasonable expectations of material and emotional comfort that depend on access to the diverse resources needed to attain them” (Narotzky and Besnier 2014:S4).

Windemere: Martha’s Vineyard’s sole nursing home whose full name is Windemere Nursing Rehabilitation, Inc.

Endnotes

1. Aquinnah was named Gay Head until 1997 (O'Neill 2013).

2. While up and down are more often thought of spatially as north and south, the nautical terms, "up-Island" and "down-Island," refer to west and east. Up-Island is farther west of the longitudinal prime meridian in Greenwich, England than down-Island, which is closer to it (Groce 1985:125, note 1). Whether one is headed up- or down-Island depends on where one is located. The up-Island towns of Chilmark and West Tisbury are viewed as down-Island to those in the westernmost town of Aquinnah. One in Chilmark is headed up-Island if traveling west to Aquinnah and is headed down-Island if traveling east to West Tisbury. Likewise, the down-Island town of Tisbury was up-Island from the perspectives of those in Edgartown or Oak Bluffs.

3. Some mainland health care organizations enabled Vineyarders to avoid taking their automobiles to mainland health care organizations. Such health care organizations picked up Vineyarders at the ferry terminal to deliver them to their appointments (then back to the ferry). Also, the "senior van" provided Vineyard elderly rides to their Cape Cod and Boston medical appointments.

4. While the percentage of full-time Vineyarders who reported that they had been diagnosed with depression appeared higher than the mainland US, part-time Vineyarders' rates appeared similar to the US (Becker and Silberstein 2006:54 citing U.S. Department of Health and Human Services 1999 and Kessler et al. 2005).

5. The Martha's Vineyard Health Report used the Centers for Disease Control's (2003) definition of "excess alcohol consumption" which was one's ingestion of five or more drinks on at least one occasion each month during the previous year (Becker and Silberstein 2006:44). Martha's Vineyard's full-time population (31.0 percent) who reported that they had met the above criteria for "excess alcohol consumption" was nearly twice the percentage of the US population (16.4 percent) and significantly more than the Massachusetts population (18.3 percent) (Becker and Silberstein 2006:44 citing Centers for Disease Control National Center for Chronic Disease Prevention and Health Promotion 2003). Also, the percentage of full-time Vineyarders making this claim exceeded that of Martha's Vineyard part-time residents (25.0 percent) (Becker and Silberstein 2006:44).

6. For universalistic act utilitarians, the goodness or badness of each particular act is determined by its consequences for everyone. A universalistic act utilitarian's criterion is how it impacts all mankind or all sentient beings (Smart 1972:207).

7. Rational actions are those actions carried out on the basis of "purely objective considerations" (Gerth and Mills 1946:215). There is an emphasis on impersonal detachment designed to eliminate personal considerations from official decisions (Gerth and Mills 1946:199, 215; Weber 1947:340).

8. Digitalis prolongs the diastolic phase and increases systolic contraction force to mitigate effects of congestive heart failure (Cornell University College of Agriculture and Life Sciences 2015).

9. As explained to those who objected to their statements being used, their wishes were granted if no one else (who provided permission) said the same. There was only one omission throughout this work for this reason.

10. A PDF file of each town's property assessments was changed from being ordered alphabetically to being ordered numerically by the property values. Those Vineyarders of a given town who owned the property (or properties) of the highest value was listed first and the Vineyarder who owned the property of the lowest was listed last.

11. Unlike while living on the mainland, Martha's Vineyard's wealthy and super wealthy are more apt to interact with people of other socioeconomic statuses. While several events on Martha's Vineyard attracted the wealthy (given the charge for admission), wealthy Vineyarders may have taken part in events that attracted less wealthy Vineyarders. Such events may have included a spaghetti dinner whose admission charge excluded few or a lecture that was free of charge.

12. This roundabout was being proposed at the Edgartown-Vineyard Haven Road and Barnes Road intersection. A few years later, the roundabout was built. Some Vineyarders who had rejected this proposal claimed that, in retrospect, the roundabout was in keeping with their Vineyard ideals. Martha's Vineyard's only traffic light was one used occasionally to signal to drivers that the Beach Road drawbridge that joins the Oak Bluffs and Vineyard Haven is about to rise.

13. A study of 13,575 US physicians found that physicians reduced their working hours per week (on average) from 55 hours during 1977-96 to 51 hours during 1997-2008 (Hawkins 2012:2, 28 citing Staiger 2010:747-753).

14. Goldschmidt's (1978) study took place in California and Mills and Ulmer's in three US cities. These cities were located in New Hampshire, New York, and Michigan (Lyson 2004:65, 66).

15. These acres include the Gay Head cliffs, Lobsterville dunes, and cranberry bogs (Fein 2007:12). Approximately 300 enrolled members made up the Chappaquiddick Tribe of the Wampanoag Indian Nation (Kennedy 2017:47). They do not have tribal land (Kennedy 2017:47).

16. Rents fell somewhere between \$50 a year for a lot, \$200 for a lot with a building and \$800 for a lot with a business (Blair 2006:3; Vaughn 2007:6).

17. Philip Mayer coined this term (and spelled it, “incapsulate”) in 1962 (Mayer 1962:591; Bell and Newby 1971:99). He claimed that African migrants to East London who try to join others who try to maintain tribal relations incapsulate themselves into migrant communities similar to those from where they emigrated (Mayer 1962:591).

18. Data suggested that Hospice’s executive board members fired the director in a secretive manner. Non-executive board members did not find out about the firing until *after* it took place. The director had not received any written or verbal warnings about her job performance. Although she had just raised an unprecedented amount (\$1.8 million) from a wealthy philanthropist (Wells 2002b:1), a study participant stated that the board members who fired her claimed that she had neglected her fund-raising duties. Rather, it was likely that the Hospice director negotiated for nurses receiving higher pay, vacation pay, and sick pay that led these trustees to fire her. Some study participants claimed that, after firing the director, Hospice became more money-oriented. Perhaps trustees viewed the new director as easier to control. The previous director had held a Master’s degree in nursing and board certification in palliative care and the new one held no college degree.

19. The Planetree model promotes improving hospital institutions. It seeks to provide the latest medical technology while promoting employees who personalize, demystify, and humanize the hospital experience and nurture, heal, comfort, support, educate and provide care that meets the patients’ goals (Frampton 2003:xxviii, xxix). A Planetree hospital purports to provide “patient-centered rather than provider-focused” (Chun 2005) health care in aesthetically pleasing surroundings (Frampton 2003:xxx, xxxii; Chun 2005). Hence, hospitals relax their visiting hours (24 hours a day, seven days per week), procure snacks as patients desire, provide movies for patients, and allow visitors to provide care to those they visit (if desired) (Frampton 2003:xxx-xxxi). Planetree hospitals provide healthier food choices, educational activities, entertainment, and availability of both complimentary and mainstream medical services. Also, Planetree hospitals promote information sharing with patients, and opportunities for patients to read and add notes to their medical charts (Frampton 2003:xxx-xxxii; Chun 2005).

20. Planetree President Susan Frampton noted that Planetree’s dues cost between \$5,000 and \$45,000 annually depending on the size of the hospital (Ruzich 2011). It was likely that the costs for implementing Planetree were significantly more than the dues.

21. Massachusetts General Hospital and Brigham and Women's merged in 1993 (Weinberg 2003:26).
22. To be designated as a CAH, the hospital must be located in a rural area; provide emergency services 24-hours a day, seven days a week; have 25 beds or fewer; and have patients whose length of stay for acute care is 96 hours or less (on average) (Centers for Medicare and Medicaid Services 2014:2)
23. Corporations that had located on Martha's Vineyard included Cumberland Farms (a convenience store), and Mobil, Citco, Texaco, and Shell (gas stations; Mobil also provided automobile lubrications). Earlier corporate chains included Subway (sandwiches) and All-Star (a video store) (Hart 2005:6; Gay 1998).
24. Because MVH was a nonprofit organization, it could not be sold (Carroll-Bergman 2010). Rather, its ownership was "transferred."
25. Martha's Vineyard Hospital was awarded its CAH designation in 2001 (Sigelman 2001c:1).
26. Federal regulations stipulate that Medicare must reimburse all hospitals at rates equal or greater than rates that state pays its rural hospitals (Wyland 2013). In 2008, it was Nantucket Hospital that was "demoted" from a CAH to a rural hospital (Wyland 2013).
27. Tufts rejected paying these higher rates until Partners stopped accepting Tufts insurance payments. Tufts recanted after many Tuft-insured patients were threatening to change insurers after Massachusetts's world-renown teaching hospital, MAG stopped accepting Tufts insurance (Allen and Bombardieri 2008; Allen et al. 2008).
28. These include Deaconess Metro-Boston and north shore suburban community hospitals.
29. Conditions at the FDA promoted a work culture that could be hostile toward researchers who disclosed drug safety problems and other unfavorable test results (Geyman 2004:212, 214; Multinational Monitor 2004). An FDA study found that 18 percent of its researchers claimed they had faced pressure to change their conclusions (Multinational Monitor 2004; Rost 2006:152). As the General Accounting Office (2002) noted, FDA officials who did not "play ball" received harassing phone calls from industry (Geyman 2004:210, 212).
30. Before Medicare was enacted, insurers cancelled many among the fewer than one half of elderly who held health insurance (Quadagno 2004:32). Either insurers cancelled their policies if they used the insurance or the policyholder chose to drop their insurance after costs for it increased (Quadagno 2004:32).

31.It cost an additional \$6,800 to include one's spouse and an additional \$2,000 to include a child 15 years of age and older (Knope 2008:12).

32.A high-ranking HCA claimed that MVH minimum wage employees paid 30 percent of the costs (\$2,000 annually) for their MVH employer-subsidized health insurance.

33.Approximately 70 percent of those filing personal bankruptcy do so under Chapter 7 of the bankruptcy code. In Chapter 7, all nonexempt assets are liquidated and the bankrupted are no longer responsible for paying their debts. Under Chapter 13, repayment plans are negotiated and people could keep their property as long as the payment plan is followed. Under both Chapters 7 and 13, the bankrupted must pay their taxes, student loans, alimony, and child support. If they do not pay their home mortgages and automobile loans, their properties will be foreclosed and their automobiles repossessed (Himmelstein et al. 2005:W5-64).

34.While some Vineyarders claimed that Brazilian immigrants were beneficial because they eased labor shortages (Burrell 2005:9) and accepted job offers that US citizens tended to find undesirable, others rejected immigrants who bid lower on potential jobs (especially in landscaping and construction) or worked for lower wages than US citizens.

35.Study participants claimed that Eastern Europeans and Jamaicans filled the employment niche Irish immigrants and more recently, US college students held. United States college students lost interest in working summers on Martha's Vineyard because of Martha's Vineyard's high cost of living.

36.Close to 500 Cape Cod, Nantucket, and Martha's Vineyard employers employ somewhere between five thousand to seven thousand H-2B workers each year (Christensen 2008).

37.A physician's power is limited if he tries to pressure a nurse to carry out an inappropriate order. In such a case, a nurse may bring the physician's wrongful order to her nursing supervisor's attention. It is part of such a supervisor's job to defend a subordinate professional's refusal to carry out an inappropriate order. An example of this was provided while practicing nursing in New York state. A physician changed an order from Demerol every hour to Demerol every half hour because he was angry with the nurse taking care of that patient.

38.Windemere applicants from the mainland tend to be frail parents of first-generation Vineyarders whose progeny desire they live nearby.

39.To qualify, patients must have been hospitalized for at least three days (Centers for Medicare and Medicaid Services 2015:7).

40.Such imaging equipment included a spiral CT scanner, ultrasound imager, and digital fluoroscope (Martha's Vineyard Hospital 2001:3).

41. The Island Communications Center was opened in the 1960s (Meras 1970:4) and makes up an important, albeit largely invisible part of the emergency response team. Tele-communicators are those who answer the telephone and summon help for those who dial “911” to report an emergency. Tele-communicators dispatch radio calls to direct public safety resources. Tele-communicators “orchestrate the response of 66 Island agencies” including ambulance, police, and fire services (Hefler 2007:3). They provide instruction about first aid that may be administered before EMTs arrive. Tele-communicators are certified in emergency response, emergency medical, cardiopulmonary resuscitation, suicide intervention, domestic violence prevention, fire service, law enforcement, computer-aided dispatch, and state and national disaster training (Hefler 2007:34). From July 1, 2006 to June 30, 2007 tele-communicators received 1,669 emergency “911” calls; 898 non-emergency “911” calls; 859 miscellaneous “911” calls; and 605 calls for those testing 911 calls (to make certain it works). The telecommunication center received 51,126 police officer requests for a record check; 20,297 computer-aided dispatch radio calls; 2,420 fire, burglar and carbon monoxide alarm responses (Hefler 2007:35).

42. Other county programs include Vineyard Smiles to help school children access dental care; Diabetes Disparities Collaborative to provide outreach, health care and education to people “of color;” Island Medical Interpreter Services to help those with language barriers to communicate with their clinicians; and Childbirth Education, a program that provides childbirth classes in Portuguese.

43. Just before the turn of the millennium, Robert A. Iadicicco (1999:15) stated, “the board of trustees is still a good-old-boys club.”

44. Woodin was fired after just 13 months, though his employment contract had stipulated five years (Wells 2017b:1, 14; Wells 2017c:1; *Vineyard Gazette* 2017a:8; *Vineyard Gazette* 2017b:12).

45. While Boston Director of Developments’ salaries ranged from \$55,000 to \$140,000 in 2017 (Payscale, Inc. 2017; Glassdoor 2008-2017; LinkedIn 2017) and MAG’s Director of Development salaries ranged from \$109,208 to \$117, 531 (Glassdoor 2008-2017), MVH’s Director of Development was paid \$158,497 in fiscal year 2015 (Wells and Breslauer 2017:7).

46. Also, the board’s vice chairman had been on the board since 2004 and the board secretary since 2003 (Wells and Breslauer 2017:7).

47. In 1999, more than 3,000 organizations with interests in health care were registered to lobby statehouse policymakers (Geyman 2004:199). In 1996, the top 500 US corporations contributed more than \$500,000 each to policymakers (Democrat and Republican) (Geyman 2004:202). Only four percent of US citizens contributed directly to a political office holder or a political party (Geyman 2004:202). Less than one-quarter of

a percent of US citizens made such contributions for more than \$200 (Geyman 2004:202).

48. For example, in 2009 after Humana officials expressed a negative opinion about health care reform, US Department of Health and Human Services officials sanctioned Humana (Schweizer 2013:55-56). Also, they pressured Forest Labs[®] officials to replace a CEO who would not cooperate with government officials (Schweizer 2013:55).

49. While Martha's Vineyard shares attributes with other islands, it is inherently unique. That is because any one person or group of people located on Martha's Vineyard cannot occupy another island simultaneously. No two people can occupy the same space at the same time. The same could be said about a grain of sand, a strand of eel grass, a drop of lake water and a vista.

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