

JANELLE S. TAYLOR
Department of Anthropology
University of Washington

The Story Catches You and You Fall Down: Tragedy, Ethnography, and “Cultural Competence”

Anne Fadiman's The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures (Noonday Press, 1997) is widely used in “cultural competence” efforts within U.S. medical school curricula. This article addresses the relationship between theory, narrative form, and teaching through a close critical reading of that book that is informed by theories of tragedy and ethnographies of medicine. I argue that The Spirit Catches You is so influential as ethnography because it is so moving as a story; it is so moving as a story because it works so well as tragedy; and it works so well as tragedy precisely because of the static, reified, essentialist understanding of “culture” from which it proceeds. If professional anthropologists wish our own best work to speak to “apparitions of culture” within medicine and other “cultures of no culture,” I suggest that we must find compelling new narrative forms in which to convey more complex understandings of “culture.” [medical education, cultural competence, tragedy, ethnography, theories of culture]

Love Story

There is a certain kind of love story that tells of how a passionate infatuation gradually changes into something different, as time and experience grant new perspectives on the beloved, on the self, and on the broader context that has brought the two together. I could tell just such a story about Anne Fadiman's *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (1997). I read this book in January 1999 and loved it. Now, after living with the book for several years, rereading it several times, and using it in teaching medical anthropology, I have come to a quite different, more clear-eyed and critical appreciation of it.

Over these same years, *The Spirit Catches You* has quickly become a canonical text for burgeoning efforts to impart “cultural competence” to health care practitioners.

It thus deserves our serious consideration not only as a remarkable book about issues of medicine and culture but also as a sociocultural phenomenon in its own right. I offer here a critical reflection, born of love, on this book and the uses to which it has been put in medical education, opening out from the text itself onto larger questions concerning the relationship between theory, narrative form, and teaching.

What I loved about *The Spirit Catches You* was its irresistible narrative drive, the almost magical power of Fadiman's storytelling; what troubles me about the book now is the way that it presents "culture" as a reified, essential, static thing. Simply to jump to the critique without acknowledging the love would be disingenuous. More importantly, however, it would miss the point: The book's narrative is so compelling precisely *because* it employs such a simplistic model of "culture." What's problematic about the book from the point of view of the anthropological theorist, in other words, is precisely what's gripping about it from the point of view of the reader. The story catches you and you fall down.

And stories *do* catch us, including those of us whose relationship to reading has been quite thoroughly "disciplined" through the course of our formation as professional anthropologists. I cannot be the only one who experiences some difficulty reconciling "the anthropological theorist" with "the reader" in my own life and person. The anthropological writings that I most admire are those that articulate a more complicated, processual, performative understanding of "culture"; for very principled theoretical reasons, these are generally also works that consciously and purposely tweak and disrupt the flow of narrative. Kathleen Stewart, for example, explains in the prologue to her innovative ethnography of cultural poetics in Appalachia:

We need to approach the clash of epistemologies—ours and theirs—and to use that clash to repeatedly reopen a gap in the theory of culture itself so that we can imagine culture as a process constituted in use and therefore likely to be tense, contradictory, dialectical, dialogic, texted, textured, both practical and imaginary, and in-filled with desire. . . . This book, then, is not a smooth story that follows the lines of its own progress from beginning to end as a master narrative would but a collection of fits and starts in the moves of master narrative itself. . . . It tells its story through interruptions, amassed densities of description, evocations of voices and the conditions of their possibility, and lyrical, ruminative aporias that give pause. [Stewart 1996:5–7]

I find, however, that personally I cannot subsist on a steady diet of such writings. My needy love of stories persists, and leads me to devour a constant stream of fiction, with a bit of history and journalism mixed in. I carry on a sort of secret second life as a reader, quite compartmentalized from my official life as a scholarly reader, indulging in narrative pleasures quite at odds with the theoretical principles that I admire. *The Spirit Catches You* is one of the few books to cross this divide, migrating from my pleasure reading into my work.

More than 15 years ago, Mary Louise Pratt asked, famously, why anthropologists, "such interesting people doing such interesting things, produce such dull books? What did they have to do to themselves?" (Pratt 1986:33). The obvious next question, which we have mostly avoided asking, is "what did we have to do to ourselves" in order to *read* not only books that are "dull" (let's just admit that we

try to avoid those), but also books that—for very good reasons—refuse the ordinary pleasures of narrative? Whatever the answer(s) to this question, we can hardly expect that others outside the profession will replicate the peculiar contortions to which we have subjected ourselves. The enormous popularity and influence of *The Spirit Catches You* challenge us to find compelling narratives that can convey more complex conceptualizations of “culture.”

The term *culture* thrives in many contexts outside of academic anthropology, including medical education (where it underwrites efforts to instill “cultural competency”), as well as science, law, and other *cultures of no culture*, to use Sharon Traweek’s term (Traweek 1988:162). What “culture” is taken to mean in these contexts is generally quite distant from, if not actually at odds with, the current state of discussions of “culture” within the discipline of anthropology. If anthropologists wish our own work to speak to these “apparitions of culture” (Helmreich 2002)—and I believe we should—then we must figure out how to both stay true to our theories, and tell stories that will catch people.

For those who may not yet have been caught by it, *The Spirit Catches You* recounts the story of Lia Lee, the child of Hmong immigrants from Laos born in Merced, California, in 1982. Beginning at three months of age, Lia began suffering terrifying seizures, which her American doctors diagnosed as epilepsy and treated with powerful medications, but that her family understood as evidence of “soul loss” and treated with herbal remedies and the services of a Hmong shaman, in addition to irregularly administering the prescribed medications. Over the course of several years, and through many harrowing crises, Lia’s doctors and her parents struggled mightily against the disease and also, all too often, against each other. At one point, convinced that her parents’ inability and/or unwillingness to administer her medications as directed was harming Lia, her doctors initiated proceedings that resulted in her removal to foster care for an entire year, though her family eventually succeeded in winning custody again.

In 1986, Lia suffered “the big one,” an intractable seizure compounded by sepsis and shock, which left her comatose and profoundly brain damaged. In this state, she was returned home to her family’s attentive care, where she remains to this day. Fadiman tells this story in chapters that alternate between recounting the course of Lia’s young life and her illness and delving into Hmong folklore, religion, ethnomedicine, and history, including the history of involvement in the Vietnam War and the subsequent resettlement of Lia’s family and many other Hmong refugees in the United States.

I am not the only one who has fallen in love with Fadiman’s book. Critics have certainly loved it; *The Spirit Catches You* was awarded the National Book Critics Circle Award, and each copy comes lavishly adorned with glowing praises excerpted from reviews written by well-known figures, for the very best national publications. The broader reading public, too, loves *The Spirit Catches You*. Current paperback editions include a “Reader’s Guide” at the end, which is designed to facilitate discussion, and even at this writing, some five years after the book’s publication, it continues to be prominently displayed in several of my local bookstores. At California State University–Chico, *The Spirit Catches You* was selected as a “Book in Common” for the 2001–02 academic year, meaning that it was to be read by all entering freshmen and discussed in a variety of venues over the course of the year.

Within the more specialized realms of medical anthropology and cross-cultural medicine, *The Spirit Catches You* has proven to be perhaps the single most influential book in recent memory. Many medical anthropology courses (including some of my own) devote a week or more to it. Perhaps more surprising, *The Spirit Catches You* is required reading for all first-year medical students at the University of Minnesota, the University of Virginia, and the University of California—Irvine. Even where it is not required of all students, Fadiman's book is widely assigned for courses on topics such as cross-cultural medicine, cross-cultural nursing, doctor-patient relations, and medical ethics, at schools of medicine, nursing, and social work all around the country. Indeed, *The Spirit Catches You* has rapidly become a classic text for programs designed to foster "cultural competence" in health care practitioners—programs whose emergence during the 1990s the book itself recounts (Fadiman 1997:270–275).

Most anthropologists can only gaze with admiration and envy on such success, knowing full well that our own writings will never receive a similar reception. What is it about *The Spirit Catches You* that catches us so?

Tragedy

If tragedy is a conflict of two goods, if it entails the unfolding of deep human tendencies in a cultural context that makes the outcome seem inevitable, if it moves us more than melodrama, then this fine book recounts a poignant tragedy. . . . It is a tale of culture clashes, fear and grief in the face of change, parental love, her doctors' sense of duty, and misperceptions compounded daily until they became colossal misunderstandings. It has no heroes or villains, but it has an abundance of innocent suffering, and it most certainly does have a moral.

—Melvin Konner [1997:28]

Reviewers, particularly those with medical training, have hailed *The Spirit Catches You* as a work of "superb, informal cultural anthropology," and, at the same time, a "poignant tragedy" that holds a "lesson" for practitioners. That readers find the book moving matters a great deal—a point perhaps too easily forgotten by those of us who have acquired a taste for the rather indigestible genre of the ethnographic monograph. Doctors, nurses, medical students, and others can, it seems, be induced to swallow what might otherwise seem like arcane ethnographic information about Hmong history and folklore, if they encounter these while caught in the grip of a tragic narrative. *The Spirit Catches You* is so influential as an ethnography, in other words, because it works so well as tragedy. Reviewing the book for the *Journal of the American Medical Association*, David H. Mark draws just such a conclusion:

I recommend this book wholeheartedly to anyone, but particularly to those interested in issues in cross-cultural medicine. It is compellingly written, from the heart and from the trenches. I couldn't wait to finish it, then reread it and ponder it again. It is a powerful case study of a medical tragedy that you would never wish upon yourself or any colleague, but because of this author's extraordinary work, you can reap its important lessons without such great pain. [Mark 1998]

I believe this formulation is worth **taking** quite seriously. What does it mean for ethnography to take the form of a tragedy? And what are the "lessons" that such a tragedy conveys?

A story that ends with a small child slipping into an irreversible coma is among the saddest that it is possible to tell. Yet a tragedy is more than simply a story with a sad ending—or even an extremely sad ending. As Melvin Konner suggests, in his review of *The Spirit Catches You*, to qualify as an example of "tragedy," as a specific dramatic narrative genre, a story must be sad in a very particular way. On the nature of tragedy, the ancients, writing during its golden age, remain important guides. Amélie Rorty glosses Aristotle's definition of the tragic as:

an imitative representation (*mimesis*) of a serious (*spoudaios*) action, dramatically presented in a plot that is self-contained, complete, and unified. The protagonists of tragic drama are admirable, not technically speaking heroes or demigods, but larger and better versions of ourselves. In the finest tragedies, it is the character of the protagonist that makes him susceptible to a deflection—to an erring waywardness—that brings disaster, producing a reversal in the projected arc of his life. [Rorty 1992:2]

Although we may speak of the "erring waywardness" that leads to the hero's downfall as a "tragic flaw" or a "tragic error," both of these are arguably inadequate translations of the Greek term *hamartia*. Amélie Rorty argues that for Aristotle, *hamartia* means neither simply a character flaw of the sort that makes the protagonist less than admirable, nor simply a cognitive mistake, but, rather, the particular kind of error that accompanies a particular kind of virtue, and therefore a special vulnerability of someone whose character is admirable because it exhibits that virtue:

Concentration blurs what is at the periphery of attention; courage sets natural caution aside; great-heartedness carries the possibility of arrogance; a person of grandeur, with an unusual scope of action, can readily lose his sense of proper proportion, forget his finitude. Everything that is best in the protagonists makes them vulnerable to their reversals. [Rorty 1992:11]

Fundamentally, then, tragedy springs not from mistakes that could and should have been avoided, so as much as from an irony intrinsic to human nature: To pursue the good requires that we act in the world, but the same quality of purposiveness that allows us to take right action can also blind us to our own error and lead us into disaster.

The lesson of tragedy is not that we should know more, think more carefully; or that we should be more modest and less impetuously stubborn than the protagonists of tragic dramas. Because it is no accident that excellence sometimes undoes itself, one of the dark lessons of tragedy is that there are no lessons to be learnt, in order to avoid tragedy. [Rorty 1992:18]

There are, thus, no clear morals to be extracted from tragedy; these are no Aesop's fables. If tragedy holds any lesson at all for its viewers, it is not how to avoid tragic outcomes but how to *endure* them, as we observe the nobility with which the protagonist faces his or her demise, and learn what it means to exhibit virtue in the face of a tragic reversal of fortune.

The purpose of tragedy is not to teach lessons but, instead, to arouse in viewers the emotions of pity and fear, in order to effect a "catharsis"—a purifying and a purging—of them. This catharsis is pleasurable for the viewers of tragedy, but,

according to Aristotle, it also serves an important social function: It recalibrates the emotions so as to enhance the ability of the person, not only to act but to feel in harmony with the social order:

The classical notion of catharsis combines several ideas: It is a medical term, referring to a therapeutic cleansing or purgation; it is a religious term, referring to a purification achieved by the formal and ritualized, bounded expression of powerful and often dangerous emotions; it is a cognitive term, referring to an intellectual resolution or clarification that involves directing emotions to their appropriate intentional objects. All three forms of catharsis are meant, at their best, to conduce to the proper functioning of a well-balanced soul. [Rorty 1992:14]

This brief detour into aesthetic theory necessarily glosses over many subtleties, but it nonetheless clearly suggests that tragedy as a genre comes already equipped with a venerable tradition of thought about how this particular kind of narrative works, what it does to and for its viewers, and what it accomplishes for society.

Approaching *The Spirit Catches You* from the perspective of how it works as a tragedy raises interesting questions about how it works as an ethnography. In classical tragedy, as we have seen, it is the protagonist's hamartia, the characteristic weakness that accompanies his or her particular virtue, that impels the story irresistibly forward toward its disastrous conclusion. What is it, we might ask, that drives the "medical tragedy" of *The Spirit Catches You*?

Accident Report

An answer presents itself already in the book's subtitle: *A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. The story of Lia Lee is presented, from the first, as the story of a "collision"—one that, like some terrible car accidents, has left a young person in a coma, hovering between life and death. What caused this crash, and whose fault was it? If such a beautiful book could be condensed to the form of an accident report, its one-line verdict would be that this "collision" was caused by "culture."

Although the differences between Lia's parents and her doctors are many, the key difference from which the tragedy unfurled was between the ways that their respective cultures made them understand Lia's illness and act in response to it. Lia's parents responded to her illness in one way because Hmong culture led them to do so, while the culture of U.S. medicine led Lia's doctors, especially Neil Ernst, to respond in another way altogether. To phrase it in the jargon of medical anthropology, we might say that Lia's tragic demise resulted from the encounter between two different "explanatory models" of illness grounded in two different "cultures." This basic understanding of what happened is implicit throughout Fadiman's text:

Dan [Murphy, one of Lia's doctors at Merced County Medical Center] had no way of knowing that Foua [Lia's mother] and Nao Kao [Lia's father] had already diagnosed their daughter's problem as the illness where the spirit catches you and you fall down. Foua and Nao Kao had no way of knowing that Dan had diagnosed it as epilepsy, the most common of all neurological disorders. Each had accurately noted the same symptoms, but Dan would have been surprised to hear that they were caused by soul loss, and Lia's parents would have been surprised to hear that they were caused by an electrochemical storm inside their daughter's head that had been stirred up by the misfiring of aberrant brain cells. [Fadiman 1997:28]

Not realizing that when a man named Xiong or Lee or Moua walked into the Family Practice Center with a stomachache he was actually complaining that the entire universe was out of balance, the young doctors of Merced frequently failed to satisfy their Hmong patients. How could they succeed? . . . The medical schools they had attended had never informed them that diseases are caused by fugitive souls and cured by jugulated chickens. [Fadiman 1997:61]

“How could they succeed?” “They had no way of knowing.” As Fadiman tells it, each party acted in the way that made sense to them, and for them, as members of their respective “cultures.” Being who they were, they could hardly have acted otherwise. Lia’s story is a tragedy of culture—or more specifically, a tragedy of distinct “cultures”—because it was the difference between their respective cultures that sent Lia’s parents and her doctors hurtling headlong toward each other.

The force of the resulting collision was dramatically increased, however, by a trait that the two sides shared in common: both were fiercely uncompromising. Their unwillingness to compromise, their constitutional inability to bend before the will of another, was, for both parties, the hamartia, the tragic weakness that is the flip side of all that is admirable about them.

History Lesson

In Foua and Nao Kao’s case, their unwillingness to compromise appears to be less a quality of their individual personalities, than the expression of a deeply ingrained trait of their culture, which, in Fadiman’s telling, is the single consistent thread that runs throughout Hmong history. Foua and Nao Kao, and the Hmong more generally, are unwilling to bend to the will of others who are more powerful than themselves, if this would compromise their cultural integrity.

This characteristic trait has, as Fadiman explains, enabled the Hmong to survive as a distinct culture, despite the many other more powerful cultural groups that have sought to dominate or assimilate them, from ancient China to contemporary America:

For as long as it has been recorded, the history of the Hmong has been a marathon series of bloody scrimmages, punctuated by occasional periods of peace, though hardly any of plenty. Over and over again, the Hmong have responded to persecution and to pressures to assimilate by either fighting or migrating—a pattern that has been repeated so many times, in so many different eras and places, that it begins to seem almost a genetic trait, as inevitable in its recurrence as their straight hair or their short, sturdy stature. [Fadiman 1997:13]

There is a certain circularity here: Hmong immigrants exhibit Hmong culture, which is characterized by a fierce attachment to Hmong culture, which has the effect of preserving Hmong culture (which is characterized by a fierce attachment, etc.). To read history in this way is really to rule history out of court altogether: nothing ever changes, and in fact it *cannot* change, because these people are destined to act just this way.

In a similarly circular fashion, members of the community who behave in any *other* way are simply counted as not really Hmong. Consider, for example, an episode that Fadiman recounts:

Explaining to me once why his family shared their home with two of his brothers, one of whom had nine children, [Jonas Vangay] said, "I have another older brother who is very American now. He refuse to accept our brothers to live with him. He say, Here in the United States it is everyone for himself. I say, *I am Hmong*. For the Hmong, it is *never* everyone for himself." [Fadiman 1997:247]

One could read Vangay's description of his conflict with his elder brother as evidence that people within the community do not simply act out shared understandings and values, but instead argue and struggle over what is the right way to live, what shall count as "Hmong culture," and who gets to decide this question. As Mai Na M. Lee notes, in a review posted on the website www.hmongnet.org: "Assimilation is a highly subjective concept and one wonders if there is any way to scientifically gauge it. Also, in the present context, one is left to ponder what 'becoming more Hmong' means" (Lee 2002).

Fadiman, however, largely follows Jonas Vangay's own interpretation of the conflict. Thus, instead of regarding "Hmong culture" as something that members of the Hmong community actively produce, through a social process that can involve disagreement, conflict, and contests for power, a more hermetic vision of Hmong culture becomes self-confirming. Those who don't conform to it become "American," and "the Hmong" seem destined to remain indigestible and unmeltable "others" within U.S. society:

The Hmong came to the United States for the same reason they had left China in the nineteenth century: because they were trying to *resist* assimilation. As the anthropologist Jacques Lemoine has observed, "they did not come to our countries only to save their lives, they rather came to save their selves, that is, their Hmong ethnicity." . . . What the Hmong wanted here was to be left alone to be Hmong. [Fadiman 1997:183]

To say that the Hmong remain Hmong because they are Hmong may be somewhat frustrating as a theoretical explanation, but it works wonderfully well as a plot device. "Hmong culture" appears as an unchangeable and unstoppable entity, bound to crash into whatever gets in its path. Micaela di Leonardo, citing Eric Wolf, calls this a "billiard ball" model of culture:

Eric Wolf has argued forcefully that "the concept of the autonomous, self-regulating and self-justifying society and culture has trapped anthropology within the bounds of its own definitions. . . . By endowing nations, societies, or cultures with the qualities of internally homogenous and externally distinctive and bounded objects, we create a model of the world as a global pool hall in which the entities spin off each other like so many hard and round billiard balls." He calls for a reapprehension of political economy, in the holistic 19th-century sense, to reknit the sundered social sciences and history, and to enable us to see that the cultural "billiard balls" we apprehend are in reality historically contingent processes, parts of ongoing interactions of populations living in shifting political economies. [di Leonardo 1998:56]

The "billiard ball" vision is quite distant from the current state of debates in the discipline of anthropology, where "culture is now viewed by many to consist of sets of competing discourses and practices, within situations characterized by the unequal distribution of power" (Frank 1999:48).

The idea that Hmong history is an expression of Hmong culture, which in turn is an expression of an inevitably recurring, innate, "almost genetic" tendency, reflects a view of "culture" that leaves precious little room for its bearers to exercise any agency in the making of history, even if "not in circumstances of their own choosing." Indeed, the still and silent figure of Lia Lee at the center of this story is perhaps all too well suited to serve as the icon of such a vision of culture, for a comatose child would seem to be about as helpless, as passive, and as devoid of agency, as a human being can be. Such a reductive and determinist vision of "culture" is surprising coming from Fadiman, because she so clearly also delights in recounting the many creative and surprising ways that Hmong immigrants have made use of their own cultural resources, in the new circumstances in which they find themselves.

Part of the problem may lie in the historical sources on which Fadiman draws. She notes that:

The Chinese called the Hmong the Miao or Meo, which means, depending on which linguistic historian you read, "barbarians," "bumpkins," "people who sound like cats," or "wild uncultivated grasses." In any case, it was an insult. . . . The Chinese viewed the Hmong as fearless, uncouth, and recalcitrant. [Fadiman 1997:14]

"Barbarian" really is an all too accurate translation of *miao*, however, insofar as it is a term that does not so much designate a particular cultural group, as lump together (and denigrate) all who lie outside the charmed circle of the "we." Miao as a category has at different points in time referred to a variety of different "wild" groups of people inhabiting China's southwestern frontier:

The general term *miao*, referring to a culturally and linguistically diverse category of non-Han peoples, dates back to early writings, such as the Han period *Shi ji* and *Zhanguo ce*, in which it referred to peoples of the wild southern regions, inhabitants of a *San Miao* kingdom said to have existed around the third century BCE, and other pre-Han and Han dynasty states or tribal confederations. In the Ming period the term was applied to many indigenous peoples of the new southwestern frontier, and used interchangeably with *man* or *yi*. All three terms meant "barbarians," and did not refer to any self-defined ethnic group. [Diamond 1995:100]

To read these texts as sources on the history of the Hmong, therefore, is tricky. One runs the risk of reifying as Hmong history (and further reifying as Hmong culture) what is really a history of Han Chinese prejudices concerning their own "others." As Mai Na M. Lee notes:

Like her historical sources, Fadiman relishes this stereotype which comes to us from the dawn of Chinese history. At times she casts the Lee family in this general frame. The proud Lees refused to yield to the modern, scientifically sound knowledge of their American doctors. This obstinate trait is extended to the Hmong in present day America as Fadiman uncritically reiterates sources which proclaim the Hmong to be the most resistant to change. [Lee 2002]

Of course, Fadiman places a very positive value on the same traits that the Chinese historical sources evaluated in negative terms. This presents its own problems, however, as Lee also notes; envisioning Hmong culture in billiard-ball mode, and wanting to advocate its value and richness, Fadiman ends up rationalizing as

“culture” practices such as cheating on drivers’ tests, and kidnapping young women for brides, that are arguably better understood in terms of power relations.

Whatever other criticisms we may make of it, however, Fadiman’s reading of Hmong culture into (and out of) Hmong history has the great advantage, in terms of plot structure, of clearly setting up an unstoppable tragic trajectory. Robert Newman, reviewing *The Spirit Catches You* for the *Archives of Pediatrics and Adolescent Medicine*, articulates well this tragic perspective on “cultures”: “Given the Hmong’s refusal to assimilate, and the American assumption that new immigrants should adapt, the tragedy of Lia Lee seems almost inevitable” (Newman 2000).

Hmong immigrants’ refusal to comply with American doctors’ instructions is, Fadiman explains, a direct expression of their unchanging “culture”:

If [doctors] continue to press their patients to comply with a regimen that, from the Hmong vantage, is potentially harmful, they may find themselves, to their horror, running up against that stubborn strain in the Hmong character which for thousands of years has preferred death to surrender. [Fadiman 1997:51]

In Fadiman’s telling, then, Foua and Nao Kao are fiercely uncompromising to the same extent that they are culturally Hmong. Being who they were, they could not have acted otherwise than they did. What their doctors viewed as “noncompliance” was really an expression of the same cultural virtue-and-flaw, the same hamartia, that had also enabled the Hmong to survive adversity for thousands of years. “Culture” caused the tragic “collision.”

Personality Assessment

Though he may differ from them in nearly every other conceivable respect, Neil Ernst as he appears in Fadiman’s text is much like Lia’s parents in one important way: he, too, is fiercely uncompromising. In Foua and Nao Kao, as we have seen, this trait was a direct expression of “Hmong culture.” In Ernst, by contrast, the same tragic quality seems to be less an inborn trait shared in common with all other Americans, or all other doctors, than an idiosyncratic quality of his individual personality.

Not all doctors are so unbending. *Webster’s Collegiate Dictionary* lists two primary meanings for the word “compromise”: (1) a settlement of differences by arbitration or by consent reached by mutual concessions . . . and (2) “a concession to something derogatory or prejudicial.”

Among the doctors working with the Hmong in Merced, there were those who proved willing to *compromise* in both senses of the term. Some, such as Roger Fife, were willing to accede to the wishes of their Hmong patients, even if this meant earning the scorn of their peers for delivering what some saw as second-rate care. Others, such as Raquel Arias, struggled to persuade their Hmong patients to accept the treatment they thought appropriate but, ultimately, found it necessary sometimes to compromise their own standards, in the interest of achieving consent:

I have the same standard of care for the Hmong as I have for everyone else. . . . My hands are just tied to provide it. So I give them suboptimal care. Sometimes you can find a middle ground and try to understand where they are coming from, which is hard, but not impossible. Sometimes you can persuade them to do what you want. You keep telling them stuff and if you want it bad enough then maybe it’ll work. [Fadiman 1997:75]

In addition to introducing American doctors who pursued a variety of strategies in dealing with their Hmong patients, Fadiman cites the work of the anthropologists Dwight Conquergood and Arthur Kleinman, to suggest that it is possible, and might have been helpful, to understand medical practice itself as a process of cultural compromise. In this view, "compromise" in its first meaning of negotiating to achieve consent, need not necessarily entail "compromise" in its second, derogatory meaning. Conquergood, who spent five months during 1985 living among Hmong refugees in the Ban Vinai refugee camp in Thailand while working to design an environmental health program, achieved great success through innovative use of theater, featuring characters drawn from Hmong folklore:

Conquergood considered his relationship with the Hmong to be a form of barter, "a productive and mutually invigorating dialog, with neither side dominating or winning out." In his opinion, the physicians and nurses at Ban Vinai failed to win the cooperation of camp inhabitants because they considered the relationship one-sided, with the Westerners holding all the knowledge. As long as they persisted in this view, Conquergood believed that what the medical establishment was offering would continue to be rejected, since the Hmong would view it not as a gift but as a form of coercion. [Fadiman 1997:37]

Fadiman draws a similar lesson from Kleinman, after discussing with him the answers she believed Foua and Nao Kao might have given to his famous "eight questions," had anyone asked them. Compromise, which was just what Neil Ernst was unable to contemplate, was precisely what Kleinman insisted was necessary if doctors such as Neil were to deal successfully with patients such as Foua and Nao Kao:

Instead of looking at a model of coercion, look at a model of mediation. Go find a member of the Hmong community, or go find a medical anthropologists, who can help you negotiate. Remember that a stance of mediation, like a divorce proceeding, requires compromise on both sides. Decide what's critical and be willing to compromise on everything else. [Fadiman 1997:261]

Neil Ernst could not possibly have compromised in any of these ways, however, because his character simply would not allow it. As illustration of his character, Fadiman describes the impressively ordered division of professional and personal labor that Neil Ernst has arranged with his wife Peggy Philips, also a pediatrician, with whom he shares a practice. They demand of themselves the strictest adherence to principles of equality in their home life, just as they demand the strictest adherence to professional standards in their medical practice. Recounting how Neil and Peggy met, Fadiman writes: "They recognized in each other the same combination of idealism and workaholism that simultaneously contributed to their success and set them apart from their peers" (Fadiman 1997:41).

This "combination of idealism and workaholism" was the aspect of Neil Ernst's character that enabled him to become a more conscientious and a *better* doctor than many others. True to the classical understanding of hamartia, however, it was this same inability to compromise that led him to insist that Lia Lee receive the same complicated regime of medications that he would have prescribed for any other patient, despite the obvious difficulties it posed for her parents, who not only did not share his "explanatory model" of epilepsy but also spoke no English, did not use clocks, and were unable to read medicine-bottle labels or any other printed matter in any language. "Neil Ernst was a doctor of a different breed. It would have

gone completely against his grain to apply two different standards of care to his patients: a higher one for the Americans, a lower one for the Hmong" (Fadiman 1997:78).

When Foua and Nao Kao (not surprisingly) failed to comply with his instructions regarding her medications, it was this same inability to compromise that led Neil Ernst to initiate proceedings to remove Lia from her parents' custody. Whether this forced separation preserved Lia's physical health (as Ernst hoped), or further damaged it (as her parents believed), there can be no doubt that it caused great suffering to Lia and her parents, further eroded what little trust remained, and made this young life that much more tragic than it otherwise would have been.

Alternate Ending

Fadiman's account is at times painful to read, not because of its prose, but because the sequence of events that she describes is so maddening, and the tragic outcome seems so preventable.

—Michael Whitcomb [2002:191]

If we read *The Spirit Catches You* as a tragedy, we see that it is "culture" in a billiard-ball mode, manifested in the main protagonists' very different understandings of illness and their very similar inability to compromise, that caused the "collision" that left Lia brain-dead. As in any great tragedy, there is, at the outset, a certain parallelism between the two forces arrayed against each other.

The symmetry is not complete, however, because Foua and Nao Kao's actions appear to be more fully determined by their culture, more inevitable, than the actions of the American doctors they dealt with. As we have noted, in Foua and Nao Kao the hamartia appears as an immutable expression of their culture, wholly shared with all other Hmong (or, at least, those who have not become "American"), while in Neil Ernst it seems more an aspect of his individual personality, albeit one especially well suited to facilitate his success within the culture of U.S. medicine.

This asymmetry opens the question of whether the outcome really was inevitable, or whether it in fact could have ended differently, had Lia been treated by another doctor who did not happen to share this trait: "Might Lia Lee have been better off if her family had brought her to Roger Fife? Might Neil actually have compromised Lia's health by being so uncompromising?" (Fadiman 1997:78).

As long as Ernst's actions can be seen to have been dictated by medicine and its values, they remain intelligible in terms of hamartia. If, however, the profession that he practiced really did *not* necessitate Ernst's refusal to compromise, if these were instead simply idiosyncratic quirks of his individual personality, then the bad outcome of her case can no longer be understood in these terms. One would have to conclude that Ernst was simply a worse doctor for being such a rigid person, and the Lees were simply disastrously unlucky to have been assigned to him. If the story turns out thus to hinge on random chance, then in terms of plot structure it is no longer a tragedy in the fullest sense:

In tragedy, Aristotle insists, the central character must make some mistake or error (*hamartia*) which leads to his fall. The *hamartia* is a mistake that rationalizes the fall. So what Aristotle is excluding when he prohibits the fall of a good man is a totally irrational fall: one that occurs through no fault of the good man at all. [Lear 1992:323]

Was Lia's story really something other than a tragedy, in this sense? Fadiman writes:

I do not know if Lia would be able to walk and talk today had she been treated by Arthur Kleinman instead of by Neil Ernst and Peggy Philp. However, I have come to believe that her life was ruined not by septic shock or noncompliant parents but by cross-cultural misunderstanding. [Fadiman 1997:262]

Chance did play a role, and it's possible that Lia might have had better luck with another physician. At the same time, however, it was not just chance that led a person with the particular qualities that Neil Ernst possessed to achieve professional success as a doctor. And, perhaps most importantly, it was not by mere chance that Ernst had as little preparation as he did, to deal with cultural difference in medical practice. The kind of misunderstandings that arose between Ernst and the Lees were neither completely idiosyncratic, nor "totally irrational"; they "made sense" in terms of the culture and social organization of U.S. medicine.

Lia's demise was thus not the product of simple bad luck. But was it really inevitable, in the manner of tragedy? Fadiman expresses hope that such misunderstandings, and the disastrous results that follow from them, might in the future be averted or at least minimized through measures already being instituted in some places, such as integrating traditional healing practices with biomedical treatment, hiring interpreters as permanent members of the hospital staff, and, perhaps most importantly, incorporating cross-cultural issues into medical education. As hopeful signs of change, Fadiman cites certain changes at the Merced County Medical Center where Lia was treated, including the training seminar conducted by the Seattle-based Cross Cultural Health Care Program. On the national level, she also notes the advent, over the course of the 1990s, of medical school curricula designed to address cross-cultural issues. The American Academy of Family Physicians in 1996 issued a set of curricular guidelines for "Culturally Sensitive and Competent Health Care," and a number of other medical professional organizations have since followed suit. At Harvard, the University of Wisconsin, and a number of other medical schools, curricula have been substantially redesigned to include elements specifically intended to help medical students develop "cultural competence."

Such efforts seem to hold out the promise that tragedies such as Lia's can be averted in the future. Ultimately, however, Fadiman retreats from Kleinman's and Conquergood's vision of medical practice as a process of cultural compromise:

Once, several years ago, when I romanticized the Hmong more (though admired them less) than I do now, I had a conversation with a Minnesota epidemiologist at a health care conference. Knowing she had worked with the Hmong, I started to lament the insensitivity of Western medicine. The epidemiologist looked at me sharply. "Western medicine saves lives," she said. Oh. Right. I had to keep reminding myself of that. It was all that cold, linear, Cartesian, non-Hmong-like thinking which saved my father from colon cancer, saved my husband and me from infertility, and, if she had swallowed her anticonvulsants from the start, might have saved Lia from brain damage. Dwight Conquergood's philosophy of health care as a form of barter, rather than a one-sided relationship, ignores the fact that, for better or for worse, Western medicine *is* one-sided. Doctors endure medical school and residency in order to acquire knowledge that their patients do

not have. Until the culture of medicine changes, it would be asking a lot of them to consider, much less adopt, the notion that, as Francesca Farr put it, “our view of reality is only a view, not reality itself.” However, I don’t think it would be too much to ask them to *acknowledge* their patients’ realities. [Fadiman 1997:276]

Here, nearly three hundred pages into the book, the inevitability of the story’s outcome is reestablished, and its structure as a tragic narrative restored, but on different terms. “Culture” may not have compelled Neil Ernst and Lia’s other doctors to think and act as they did, but “science” did. Some individual doctors might be more able than others to “acknowledge their patients’ realities,” and those differences do matter. On a deeper level, however, doctors as a group possess “knowledge that their patients do not have,” and their understanding of illness is therefore far more than just “a view of reality” on a par with any other. Foua and Nao Kao may have had their “explanatory model,” but Neil Ernst, being a doctor, had true medical knowledge of her illness, which really *did* compel him to think and act in ways that were fundamentally at odds with their wishes. In the end, then, Lia’s demise turns out to be not so much a “collision of two cultures,” as a tragic encounter between (Hmong) “culture” and (U.S. medical) “science.”

Ghost Story

It was so haunting. I started to have nightmares that it was going to happen, and I would be the one on call, and I couldn’t stop it and she was going to die right before my eyes. It was inevitable. It was just a matter of when.

—Neil Ernst, quoted in Fadiman [1997:118]

Asserting the superiority of scientific medical knowledge preserves the narrative structure of *The Spirit Catches You* as a tragedy, but it also conjures the specter of medical failure. “*Western medicine saves lives*,” but not always. Physicians cannot eradicate suffering, illness, and death—and, indeed, cannot avoid sometimes causing them. The more confident and arrogant its claims, the more medicine is haunted by its failures, and few figures embody medical failure more vividly than Lia Lee, helpless and inert, lovingly and laboriously tended at home by her overburdened and heartbroken family.

As it turns out, the final disastrous seizure that left Lia in a coma was misdiagnosed by her American doctors, may have been brought on by the medicine they had prescribed for her, and had nothing whatever to do with her parents’ “noncompliance.” Terry Hutchison, the pediatric neurologist who had overseen Lia’s care while she was being treated at a hospital in Fresno, explained to Fadiman that the seizure was brought on not by epilepsy but by septic shock, caused by a bacteria to which her medications may have made her more susceptible. “Go back to Merced,” he said, “and tell all those people at MCMC that the family didn’t do this to the kid. We did” (Fadiman 1997:255).

Could this tragedy have been averted, then? Could Neil Ernst—should he—have recognized the underlying sepsis and treated it? Bill Selvidge assures Fadiman: “Neil leaves no stone unturned. . . . If Neil made a mistake, it’s because every physician makes mistakes” (Fadiman 1997:256).

Although every physician makes mistakes, not all mistakes are alike. In a study of how mistakes are dealt with and medical failure managed in the training of surgeons, Charles Bosk argues that the profession distinguishes sharply between "technical" errors, which are tolerable and addressed through retraining, and "moral" errors, which are intolerable and lead to professional exclusion (Bosk 1979). The mistake that Neil Ernst made, by failing to correctly diagnose and treat Lia's last and worst seizure, would fall into neither of these categories of "error." As Bosk explains:

Not all diagnoses and treatments that later experience proves wrong are mistakes; some are actions that any reasonable physician would have made under the circumstances. . . . Physicians draw the line between what was a reasonable treatment option that subsequent events proved wrong and a course of action that was indefensible given the facts at hand, an error. [Bosk 1979:24]

What Lia Lee's demise represents, then, is the residue of failure that inevitably accompanies medical practice, even when physicians do the very best they possibly can, and make *no* "errors" recognizable as such.

In terms of the plot structure of tragedy, the inevitability of medical failure is somewhat ambiguous, being less specifically rooted in individual character than hamartia, yet at the same time more closely tied to that character's actions, and so less "irrational," than simple blind luck. It clearly resonates, however, with "one of the dark lessons of tragedy. . . . That there are no lessons to be learnt, in order to avoid tragedy" (Rorty 1992:18). The ineradicable possibility of failure lurks behind and around every claim made for medicine's success; it can be understood, perhaps, as "haunting" medicine, in the sense in which Avery Gordon uses the word, to describe "that which makes its mark by being there and not there at the same time" (Gordon 1997:6). Lia Lee, consigned by medical failure to a state in which she lingers neither dead nor fully alive, is the ghostly presence that embodies this haunting possibility.

One can argue that tragedy achieves catharsis precisely by staging an encounter with just such specters, helping us deal with the potential for disaster that always haunts ordinary life, but must remain repressed in order for the conduct of ordinary life to be possible: "The belief that tragic events could, *just possibly*, happen to us does exert some pressure on our souls. . . . This is precisely the pressure which takes us to the theater. For in the theater we can imaginatively bring what we take to be a remote possibility closer to home" (Lear 1992:333). It is not difficult to imagine that physicians in training might feel this "pressure on the soul" particularly keenly, and might for this reason find the tragedy of *The Spirit Catches You* especially cathartic.

At the same time, Fadiman's narrative deals with the haunting possibility of medical failure Lia represents in another way as well: by summoning her back to life. Anthropologists have long recognized that shamanic cures work through a special form of narrative activity; perhaps the reverse is also true—perhaps narrative works through a special form of shamanic activity. Storytellers, like shamans, specialize in producing those trancelike states in which invisible and mute souls show themselves, and speak. Like shamans, they are called to their work by being themselves "afflicted" and "possessed" by stories. Fadiman understands this well; in 1998, one year after *The Spirit Catches You* appeared, she published *Ex Libris*:

Confessions of a Common Reader, a slim volume of essays about her lifelong love of books. The book begins:

When the Irish novelist John McGahern was a child, his sisters unlaced and removed one of his shoes while he was reading. He did not stir. They placed a straw hat on his head. No response. Only when they took away the wooden chair on which he was sitting did he, as he puts it, “wake out of the book.”

“Wake” is just the right verb, because there is a certain kind of child who awakens from a book as from an abyssal sleep, swimming heavily up through layers of consciousness toward a reality that seems less real than the dream-state that has been left behind. I was such a child. [Fadiman 1998:ix]

There is a quite perfect fit between shamanism as a subject of storytelling, and storytelling as a form of shamanism. Indeed, the experience of being completely engrossed in her book is as close as most of Fadiman’s readers are ever likely to come to an episode of spirit possession such as the book describes. When Fadiman concludes *The Spirit Catches You* with the words recited by the *txiv neeb* whom Foua and Nao Kao had hired to call back Lia’s soul, the reader feels the power of that incantation through the power of storytelling. Lia *can* be brought back, medical failure *can* be overcome—if not by a physician in what we usually call real life, at least by a shamanic storyteller in the powerfully real experience of reading.

Case Presentation

Physicians and medical students are not immune to the cathartic and shamanic powers of a book such as *The Spirit Catches You*, but they are often too harried, too tired, too busy cramming for required courses and navigating the other extraordinary demands placed on them to enjoy the curative effects of reading one. They already have at their disposal, however, other narrative means of dealing with the specter of failure.

Key among these is the practice of establishing their own competence by learning how to craft and perform clinical narratives:

Students were encouraged to learn new narrative forms, to create medically meaningful arguments and plots with therapeutic consequences for patients. In this process, they sharpened their biomedical “gaze” and developed their clinical reasoning. Throughout these exercises, the “psychosocial” aspects of most patients’ illnesses, their social histories and emotional states, and their lives outside of the hospitals and clinics were largely irrelevant; these data from daily life were regarded as “inadmissible evidence” in the presentations made during everyday work rounds. [Good 1995:135]

Dan Murphy, recounting to Fadiman his own experience of treating Lia Lee during one of her seizures, recalls agonizing over his inability to talk to Foua and Nao Kao, but at the same time describes precisely this experience of proving his competence by “figuring out what had happened,” in other words, creating a “medically meaningful argument” and a “plot with therapeutic consequences”:

I thought it might be meningitis, so Lia had to have a spinal tap, and the parents were real resistant to that. I don’t remember how I convinced them. I remember feeling very anxious because they had a real sick kid and I felt a big need to explain to these people, through their relative who was a not-very-good translator,

what was going on, but I felt like I had no time, because we had to put an IV in her scalp with Valium to stop the seizures, but then Lia started seizing again and the IV went into the skin instead of the vein, and I had a hard time getting another one started. Later on, when I figured out what had happened, or not happened, on the earlier visits to the ER, I felt good. It's kind of a thrill to find something someone else has missed, especially when you're a resident and you are looking for excuses to make yourself feel smarter than the other physicians. [Fadiman 1997:28]

His description makes all too clear how medical "competence" can be established and demonstrated by "performing clinical narratives," even in the face of the bleak-est inability to communicate across cultural difference.

Indeed, one might argue that establishing one's "competence" as a physician *requires* bracketing off questions of the patient's life experience. Byron Good quotes one medical student's explanation of what "presenting a case" to an attending physician involves:

Basically what you're supposed to do is take a walking, talking, confusing, disorganized (as we all are) human being, with an array of symptoms that are experienced, not diagnosed and take it all in, put it in the Cuisinart and puree it into this sort of form that everyone can quickly extrapolate from. They don't want to hear the story of the person. They want to hear the edited version. . . . You're not there to just talk with people and learn about their lives and nurture them. You're not there for that. You're a professional and you're trained in interpreting phenomenological descriptions of behavior into physiologic and pathophysiologic processes. So there's the sense of if you try to tell people really the story of someone, they'd be angry; they'd be annoyed at you because you're missing the point. That's indulgence, sort of. [Good 1994:78]

To prove one's competence as a doctor, in other words, not only does not require that one "talk with people and learn about their lives and nurture them," but indeed demands that one steel oneself *against* being caught by "the story of the person."

Yet a physician is also "a person with a story," of course, and each episode of medical failure becomes an event in *that* story as well. Here again, physicians have at their disposal narrative means of dealing with this. Two important kinds of stories circulate within (and, increasingly, beyond) the medical profession. One tells of the heroic struggles of the individual physician against illness, suffering, and the mysteries of disease. This is a story of medical heroism that plays itself out *within* "the system" of medicine. The other is the story of the heroic struggles of the individual physician against the dehumanizing effects of medicine and technology on patients, and of medical education on physicians themselves—a story, in other words, of medical heroism *resisting* "the system" of medicine.

The story of the individual physician as medical hero, it's important to note, is different from another story that we often hear told, especially in connection with biotechnology, of illness and death retreating before the glorious advance of science ("*Western medicine saves lives*"). The story of the medical hero does not banish medical failure, and thus is not haunted by it in the same way; rather, it grants failure an honored place. Indeed, the medical hero is heroic precisely *because* his or her struggles are, in the end, doomed to fail; illness, suffering, and death simply cannot ultimately be overcome. To *know* this, and to persist nonetheless in fighting to *keep* them at least provisionally at bay, is heroic because it embodies a brave and noble response to the shared human condition of being both mortal and compassionate

creatures. Doctor versus death is an endlessly gripping story, as the tens of millions of weekly viewers of television shows such as *ER* can attest.

At the same time, however, as every episode of *ER* also makes clear, doctors confront death and disease not directly, one-on-one, but in the context of “the system” of medicine. This “system” consists of a vastly complex network of social relations, including: the structure of medical education, the professional hierarchies among doctors, the organization of medicine into specialties and departments, the division of labor between doctors and nurses, the constraints imposed by insurance and law and institutional budgets, the technological infrastructure, and—last but not least—the often fleeting, always power-laden relationship between doctor and patient. The second kind of story, which we might call the “heroic resister” story, tells of the struggles of the individual doctor *against* this “system.” In this kind of story, medical failure represents not the parameters of the human condition, but an indictment of all that needs to be changed in medicine.

Donald Pollock has suggested that these two kinds of stories are less diametrically opposed than they might seem; medical education, which imparts to budding physicians both the knowledge and the social authority that anoints them as potential medical heroes within “the system,” also *systematically* imparts to each one the sense that he or she is struggling against this same “system”:

The genre I call training tales . . . adopts a seductively radical mask for the promotion of fundamentally conservative values in the play of medical power . . . the “tactics” of resistance and opposition that structure so many of these narratives may also be read as a dimension of the strategies medical institutions employ for the production of medical power, strategies that have gone unnoticed by those experiencing medical education and training. . . . That is, when the authors of these training tales believe that they are unique, or among a select few, in seeing the faults of the system of medical education or training, are they experiencing the same impression that most other doctors-in-training experience? My own sense, from interviews with numerous medical students and house officers in several different settings, is that this is in fact a common experience. [Pollock 1996:354]

When medical failure happens—when, for example, a beautiful young child slips into an irreversible coma—“attention must be paid,” sense must be made. Was this an instance of medical heroism confronting the limits of human knowledge and power? Or did “the system” fail the patient (despite the heroic efforts of the lone resister)? In working out what happened, deciding between these two different available narratives with the two different valences that they give to failure, physicians work through the question of how much agency they as individuals actually have within “the system”—a “system” that, of course, *every single person* involved with it confronts as a “system,” over and against his or her individual self. Is each doctor a lone ranger? Or is medicine one big billiard ball? Answers are bound to be rather more complicated, and always provisional—incessantly reopened, and constantly struggled with.

Indeed, it may well be that *The Spirit Catches You* makes such compelling reading partly because the “case” of Lia Lee lends itself so well to *either* story, or both. On the one hand, Lia represents the necessary limits confronted by the heroic individual doctor. On the other hand, she also represents a dramatic failure of “the system,” including not only the institutions of medicine but also those of the various

arms of the state—welfare, immigration, and social work—with which medicine is profoundly entangled. The still, silent figure of Lia here serves as a sort of empty space where physicians struggle to discern the parameters of their own power and agency within the institutions they inhabit.

A Primer of Sorts

Although Lia’s story is, of course, a tragedy, it also contains a message of hope. In part because of Lia, a generation of physicians who trained at Merced had a greater understanding of the complexity of cross-cultural medicine. . . . For health care providers of any type, this book should be required reading. For those with no other source of cross-cultural training, the book can be used as a primer of sorts.

—Robert D. Newman [2000:1278]

Whatever the verdict(s) on Lia’s demise, “cultural competence” programs that have burgeoned since the mid-1990s clearly represent an effort to better prepare both individual physicians and “the system” to deal well with cultural difference. As we noted earlier, such programs and courses have enthusiastically adopted *The Spirit Catches You* as a key text for teaching. Having explored the text in some detail now, we are in a position to ask some questions that deserve to be pursued in future ethnographic research, about the uses to which it is being put in medical education.

First, and most obviously, we might ask: What does “cultural competence” really mean? What relation does it bear to “competence” as this is constructed within medical education? If physicians-in-training establish their overall “competence” by learning to craft clinical narratives in a way that, as Byron Good puts it, “justifies the systematic discounting of the patient’s narrative” (Good 1994:78), then what does “competence” mean when we attach to it the modifier “cultural”? However one defines “culture,” does not attention to it demand, at the very least, taking an interest in what people think, and say, and what they have experienced—in short, “the story of the person”?

One way that this gets worked out in the medical school classroom, apparently, is through discussion exercises in which each student is assigned the role of one of the characters in the book, and then the group then acts out different ways that the situation could have been handled better. We might well pause to consider what it is that gets taught when medical students are asked to engage *The Spirit Catches You* in this manner. Is the book mined for billiard-ball nuggets of truth about “Hmong culture” that can tell, in advance of any actual conversations with them, what Hmong patients think and feel and want and need? And when a student is asked to assume the persona of a patient culturally different from her or himself, might this not convey to her or him that difference does not run so deep after all, that “culture” is just a sort of costume to be donned at will? When students are asked to act out a scenario from Fadiman’s book in such a way that it ends up differently, are they learning to transform a tragic narrative into a clinical narrative, and, if so, does this undermine the way that the text works as a tragedy?

And indeed, just how *does* the text work as a tragedy in the context of medical education? Recall that Aristotle understood tragedy to serve a social function: by providing a safe environment in which to cathartically work through troubling

emotions, tragedy served to recalibrate them, leaving the viewers of tragedy better prepared not only to act, but also to feel, in harmony with the social order. Does the experience of reading and discussing *The Spirit Catches You* serve a similar function in the socialization of medical students? And, if so, can it at the same time also further the goal of transforming medical education, that many people working to promote “cultural competence” sincerely hold?

Previous ethnographic research on medical education may be instructive:

Given that the clinical faculty and residents are largely responsible for producing and reproducing clinical competence, innovations in these processes and in the meanings of competence that they define will have to focus anew on clinical training settings and on those speaking and writing practices that have seldom been the object of curricular change. [Good 1995:142]

Even though requirements designed to address “cultural competence” and other “psychosocial issues” (another of those terms I hate, but I will leave that for another time) are increasingly commonly incorporated into medical school curricula, it seems unlikely that medical students as a group will take these very seriously as long as they perceive, correctly, that they are irrelevant to the *real* “competence” that they need to acquire. Unless and until efforts to instill “cultural competence” take on the task of transforming “competence” itself, I fear there will be little response to Fadiman’s plea: “I don’t think it would be too much to ask them to *acknowledge* their patients’ realities.”

Nor should anthropologists be too smugly critical of what goes on in medical schools, without also considering what goes on in anthropology classrooms. Anthropology students (especially graduate students) learn to craft and perform not the clinical narratives that are valued in the profession of medicine, but other kinds of narratives that are valued in the profession of anthropology—writing that is heavy with big names, bedangled with footnotes, shielded by a protective coating of specialized terms and authoritative references. Perhaps the ways that anthropologists-in-training confront texts really is an example of what Byron Good calls a “formative practice” (Good 1994), not all that different from the ways that physicians-in-training confront cadavers. Until the culture of academia changes, it would be asking a lot of anthropologists to consider, much less adopt, the notion that their own emotional investments in very particular narrative practices are worthy of serious reflection. However, I do not think it would be too much to ask anthropology professors to *acknowledge* their students’ realities, including the reality of falling in love with a story and being caught by a book.

Invitation

I remember telling a friend, when I finished reading *The Spirit Catches You* for the first time, that I wanted to bow down in gratitude at the feet of the woman who had written this book. I still feel that way—but now, when I picture myself bowing down before Anne Fadiman, I imagine laying at her feet, as an offering of sorts, my reflections on her work. I like to think that she would accept them graciously.

In a talk delivered in October 2001 to students at California State University–Chico, where *The Spirit Catches You* was selected “Book of the Year” and assigned

as required reading to all entering students for the 2001–02 academic year, Fadiman described the eight-year-long process of researching and writing the book:

I felt that I started pulling on a slender thread, the thread that was Lia Lee, the small sick child who is the central character of this book. I pulled on the thread and the thread became a string and the string became a rope, and then I tugged really hard on the rope and I discovered that it was attached to the entire universe. [Alderson 2001]

Like all truly great books, *The Spirit Catches You* does create an entire universe within its pages. After sojourning there, one emerges feeling that ordinary life has gained a dimension.

Each such universe between hardcovers becomes in its turn, however, a new slender thread laid in our hands—an invitation to curiosity. If I have raised critical questions concerning the model of “culture” that I find embedded in *The Spirit Catches You*, my purpose in doing so is not to demolish the universe that Fadiman has created so that I can build in its place some other more perfect universe-according-to-me. Rather, I hope to add a dimension to the ordinary act of reading this book, just as the book has added a dimension to the ordinary lives of its readers. I tugged on the thread of *The Spirit Catches You* and found that it is attached to, if not an entire universe, at least a constellation, of things gravitating together in surprising and consequential ways: billiard balls, character traits, and ghosts; medicine, shamanism, and storytelling; tragedy, ethnography, and “cultural competence”; theory, narrative form, and social practice. (And, I might add, criticism and love.)

My hope is that having seen these gravitational fields, we may see also that it is we who actively create and recreate them, even (or perhaps especially) when we feel most swept away by a story—and that we may then begin to take more responsibility for them. “Culture” is not a “thing,” somewhere “out there,” that books are “about.” It is a process of making meanings, making social relations, and making the world that we inhabit, in which all of us are engaged—when we read and teach, or when we diagnose and treat, no less than when we embroider *nyas* and conduct sacrifices.

The meanings that we make set the course for the actions that we take; they matter enormously. If what we make of a book such as *The Spirit Catches You* is a set of stereotypes about what “they” think, or a bunch of rules about how to deal with “them,” like so many specialized tools to be stashed in a briefcase and trotted out each time one of “them” shows up, then we will certainly fail to keep alive the empathetic curiosity that allows one to be thoughtfully alert to difference. And *that* carries an enormous human cost, as Fadiman has documented all too clearly. Books such as *The Spirit Catches You* and courses such as those offered in “cultural competence” curricula (as well as articles such as this one) assume their proper place when we take them not as solid lumps of congealed truth, but as goads to curiosity, invitations to make meaning, moments in the ongoing process that *is* culture.

I argued at the outset that anthropologists must find ways to both stay true to a more complex understanding of “culture” and tell stories that will catch people. That’s the talk I talked; have I walked the walk? Did I tell a “story” that catches you? Perhaps not, though I have tried my best; not all of us possess the shamanic gift. Perhaps you have slogged through this far only because you had to; academics

such as I enjoy the rather dismal security of knowing that at least a *few* other people *will* read what we write, whether it catches them or not. But even if my own attempt has fallen short, this does not mean that it is not possible to tell new kinds of stories about “culture,” and it is well worth trying.

Anne Fadiman has given us, in *The Spirit Catches You*, a beautiful, shimmering, golden thread. Around it I have now twined my own plainer, scratchier one. Please, take them in your hands and pull.

NOTES

Acknowledgments. For encouragement, helpful conversations, and good-humored tolerance of my fixation as I wrote this article, I am grateful to Michael Rosenthal and Lorna Rhodes. Many thanks to my friends Rachana Kamtekar, Bettina Shell-Duncan, Karen-Sue Taussig, Nancy Henry, Meilu Ho, Mimi Kahn, Liz Strober, Mary Scoggin, Liz Roberts, and Kelly Fryer-Edwards, for reading and commenting on it. Thanks also to Karen-Sue Taussig and Bonnie Shulman for kindly extending speaking invitations, the prospect of which helped nudge me from talking about this to writing it.

REFERENCES CITED

- Alderson, Barbara
2001 Ann Fadiman: “Go to the Edge of Your Culture.” Inside Chico State 32(4). Electronic document, http://www.csuchico.edu/pub/inside/archive/01_10_25/ann.html, accessed October 25.
- Bosk, Charles
1979 *Forgive and Remember: Managing Medical Failure*. Chicago: University of Chicago Press.
- Diamond, Norma
1995 Defining the Miao. In *Cultural Encounters on China’s Ethnic Frontiers*. Stevan Harrell, ed. Pp. 92–116. Seattle: University of Washington Press.
- di Leonardo, Micaela
1998 *Exotics at Home: Anthropologies, Others, American Modernity*. Chicago: University of Chicago Press.
- Fadiman, Anne
1997 *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York: Noonday Press.
1998 *Ex Libris: Confessions of a Common Reader*. New York: Farrar, Straus and Giroux.
- Frank, Gelya
1999 *Venus on Wheels: Two Decades of Dialogue about Disability, Biography, and Being Female in America*. Berkeley: University of California Press.
- Good, Byron
1994 *Medicine, Rationality, and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.
- Good, Mary Jo DeVecchio
1995 *American Medicine: The Quest for Competence*. Berkeley: University of California Press.
- Gordon, Avery
1997 *Ghostly Matters: Haunting and the Sociological Imagination*. Berkeley: University of California Press.
- Helmreich, Stefan
2002 After Culture: Reflections on the Apparition of Anthropology in Artificial Life, a Science of Simulation. *Cultural Anthropology* 16(4):612–627.

Konner, Melvin

1997 *Take Only as Directed: When Medicine Butts Up against Traditional Belief, Tragedy Ensues*. New York Times Book Reviews, October 19.

Lear, Jonathan

1992 *Katharsis*. In *Essays on Aristotle's Poetics*. Amelie Oksenberg Rorty, ed. Pp. 315–340. Princeton: Princeton University Press.

Lee, Mai Na M.

2002 *Book Review: The Spirit Catches You and You Fall Down*. Electronic document, http://www.hmongnet.org/publications/spirit_review.html, accessed June 26.

Mark, David H.

1998 *Review of The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. *Journal of the American Medical Association* 279(6):477.

Newman, Robert D.

2000 *Review of The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. *Archives of Pediatrics and Adolescent Medicine* 154(12):1277–1278.

Pollock, Donald

1996 *Training Tales: U.S. Medical Autobiography*. *Cultural Anthropology* 11(3):339–361.

Pratt, Mary Louise

1986 *Fieldwork in Common Places*. In *Writing Culture: The Poetics and Politics of Ethnography*. James Clifford and George E. Marcus, eds. Pp. 27–50. Berkeley: University of California Press.

Rorty, Amélie Oksenberg

1992 *The Psychology of Aristotelian Tragedy*. In *Essays on Aristotle's Poetics*. Amélie Oksenberg Rorty, ed. Pp. 1–22. Princeton: Princeton University Press.

Stewart, Kathleen

1996 *A Space on the Side of the Road: Cultural Poetics in an "Other" America*. Princeton: Princeton University Press.

Traweek, Sharon

1988 *Beamtimes and Lifetimes: The World of High Energy Physicists*. Cambridge, MA: Harvard University Press.

Whitcomb, Michael E.

2002 *Assisting Medical Educators to Foster Cultural Competence*. *Academic Medicine* 77:191–192.