

anthropologists studying violence as a cultural universal.

Participants included Brian Ferguson, professor of anthropology at Rutgers University; Eric Haanstad, a doctoral candidate from the University of Wisconsin and current SAR Weatherhead Fellow; Robert Rubinstein, professor of anthropology and international relations at the Maxwell School of Syracuse University; and Anne Irwin, chair of civil-military relations at the University of Calgary in Canada. In addition, McNamara and colleague David Price of St Martin's College represented the ongoing AAA Ad-Hoc Commission on the Engagement of Anthropologists With the US Security and Intelligence Communities.

The seminar was something of an adventure, since none of the participants were entirely sure how to define what (if any) common territory might be worth exploring in two days. To kick off the discussions, McNamara and Whitehead asked participants to consider a set of general themes, including the changing relationship between anthropology and institutions of power; anthropological theories of violence; and the politics of anthropologists, who tend to be liberal in their political leanings. In addition, Canadian colleague Anne Irwin—who recently conducted anthropological field research among Canadian infantry soldiers deployed in a combat role in Afghanistan—urged us to consider how national traditions shape distinctive relationships between the pen and the sword in different countries.

From those launching points, participants dove into two days of frank and wide-ranging discussion. Our exchanges drew heavily on fieldwork and research experience to explore anthropology

as a field in transition, from a primarily academic endeavor with a focus on area studies, to a more repatriated discipline peopled by members who are increasingly engaged with powerful institutions in both private and public sectors.

In comparing fieldwork experiences—applied and academic, abroad and at home, past and present—we discovered rich veins of thematic contrast and similarity. Whitehead and Ferguson's ideas about violence in the tribal zone resonated in fascinating ways with Haanstad's fieldwork among Thai police, as well as Irwin's experience among enlisted Canadian soldiers deployed in Afghanistan.

In turn, Irwin and Rubinstein's expertise in peacekeeping operations helped challenge taken-for-granted assumptions about the relationship between militarism and state violence. Similarly, David Price's critique of secrecy in anthropology and McNamara's experience studying people who work in high-security environments acted as contrasting touchstones for comparing and debating parallels and divergences in academic and applied anthropology. Of particular interest throughout the discussions were the stories and photos that Irwin brought from her recent fieldwork in a combat zone.

Not surprisingly, the conversations touched repeatedly on the hard facts of the present. As scholars, we are producing knowledge in a time of war. Moreover, the institutions comprising the military and intelligence communities throughout the US, Canada and Europe seem increasingly interested in drawing on the expertise of social scientists in general, and anthropologists in particular. Seminar participants spent a great deal of time exploring how we each have defined and maintained ethical lines as we engage in various field sites, and whether or not the ethics of engage-

ment vary depending on whether a war is collectively defined as "just" or "unjust."



In doing so, we discussed what it might mean for anthropologists to have an "impact" on state institutions, and whether or not it is possible to discern any impact as specifically anthropological in nature. We also considered the tradeoff between the risks of engagement in ethically fraught environments, and the benefits to the discipline from knowledge produced therein. Price's historical research contrasted with other participants' ongoing fieldwork experiences to create a lively context for our discussions of present-day anthropological involvement in and around a range of field sites—from intelligence analysts, to dark shamans, to UN peacekeepers and Thai police officers.

So—do anthropologists trying to understand the causes of violence have much to discuss with anthropologists studying, critiquing or working in and around defense and security institutions? The answer was a resounding yes. In fact, the discussions were so exciting and enlightening that the participants decided to assemble a proposal for an expanded SAR Advanced Seminar for 2008 so that we can revisit the many themes left unexplored in two short days in Santa Fe. ■

Laura A McNamara is a member of the AAA Ad Hoc Commission on the Engagement of Anthropology With US Security and Intelligence Communities. She and the SAR seminar participants thank their gracious hosts at SAR, including James Brooks, Nancy Owen-Lewis and Catherine Cocks. A special thanks to Leslie Shipman and her crew of gourmet cooks, who sustained their discussions with fabulous food.

STRATEGIES FOR IMPROVING HEALTH CARE

Closing the Gap Between Doctors and Patients

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In the consulting work my colleagues and I have carried out over the past few years we have found ourselves continually recommending to the medical establishment—doctors, pharmaceutical companies, HMOs—that it invest greater effort in attempting to understand the ways in which patients frame and experience various conditions and diseases. We continually advise consideration of the specific folk models of illness that guide patient behavior, in effect making a plea for cultural analysis and anthropological understanding.

We have been attempting to provide a baseline cultural grammar of the meanings diseases like hypertension, diabetes and arthritis have for patients and how these meanings form patients' experiences of and attempts to cope with their conditions. We have found that each condition or disease state is its own universe of meaning.

Importance of Effective Communication

My case studies show that effective communication with patients can sometimes be as important as correct diagnosis. Indeed doctors have to be good salesmen for their positions if they wish their advice to be taken seriously, for it to have the necessary authority. In order to do this they should understand the cultural factors that influence the patient mindset.

As importantly, patients' lengthy, often times circular and anecdotal narratives provide a way for doctors to incorporate aspects of the patient's folk perspective into the therapeutic process. These narratives should not be squashed short in order simply to relate the medical facts to the patient. To do so would indicate that doctors are simply interested in an attenuated form of condition management, one that eschews patients' understanding of what I have called wellness.

For instance, in our study of hypertension we found that getting the high blood pressure numbers down was only one half of the patient's goal; creating a life in emotional balance was the

patient's "wellness goal." Patients were absolutely convinced that stress and emotional imbalance were the root causes of hypertension rather than heredity, diet or being overweight.

Patients were in effect resisting the doctor's approach, not only because dieting and exercising and taking ones' medication are sometimes difficult, but also because they were being silenced. They were in effect being told that their interpretations and feelings should not be part of the therapeutic process. To improve the doctor/patient relationship we suggested that doctors work toward helping patients achieve wellness in tandem with getting the blood pressure numbers down.

In our study of hypertension we recommended that doctors engage with patients more meaningfully by allowing time for what could be called patient storytelling—realizing that patient anecdotes could contain insight that could make or break a mutually satisfactory doctor-patient relationship.

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tionship. We also recommended adding simple relaxation techniques to the therapeutic process, appreciating that while medicine works toward health, behavior modification and stress reduction contribute to wellness.

Consultation as a Rite

In the most skillful and humane consultations we have witnessed and analyzed, the patient's concerns were addressed in detail, with the doctor asking first about the patient's life situation in order to establish rapport. Effective doctors did not shy away from the often times powerful psycho-social dimensions of the patient's condition.

We recognized early on that establishing such rapport was an important part of the therapeutic process, and we quickly perceived that doctor-patient interactions were, in Victor Turner's famous phrase, social dramas or performances. Establishing rapport was but the opening act of the drama.

Viewing matters in this way provided us with another key to improving doctor-patient

interactions. We often recommend that charts be provided to doctors to help them organize consultations into distinct stages.

After listening to patients' dialogues about their situation and condition, and by responding to them, the doctor begins to establish a spirit of collaboration with the patient. Here doctor and patient begin a shared search for the right course of treatment, the right prescription, the right therapeutic course of action.

This search can be understood as equivalent to the liminal or transition phase in a rite of passage. In it the patient begins to feel that the doctor is responding to personal concerns and is supporting him or her in a search for wellness as well as treatment. In this phase the doctor begins to share medical knowledge, but makes clear that his or her suggestions are based on what the patient has related about his or her needs, experiences and perceptions. The doctor acts as a guide who shares knowledge through collaboration.

The final stage of the consultation is analogous to the phase of reincorporation in a rite of passage. It is achieved only as a consequence of the doctor first establishing rapport and a spirit of collaboration with the patient. Persuading the patient about the correct-

ness of the advice given involves managing an emotional transformation—moving the patient emotionally from ambivalence and insecurity about his or her condition and possible medications and treatment options, to a sense of security with trust in and commitment to the received advice.

With these points in mind we often advise that videos of successful doctor-patient interactions be created and played in patient waiting rooms. The videos would film interactions focusing on various conditions at various stages in their progression.

We also suggest that patient testimonials be filmed and displayed: patients talking about their conditions, its affects on their lives, their approaches to managing the conditions and the role they would like their doctors to play in their health dramas. As a corollary of this tact we suggest that doctor testimonials be filmed: doctors explaining a condition from their perspective, and what they find most useful in treating a patient. ■

Cultural anthropologist Thomas Maschio consults for businesses and nonprofits. His original ethnographic research focused on religion, symbolism and ceremonialism in Papua New Guinea.

Training Students to Do Health Disparities Research

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Teaching may be what we do most of the time, but in an applied program, we are concerned with teaching students to do applied anthropology. So I usually include an actual applied research project in my graduate seminars in medical anthropology.

A current national health priority is the elimination of health disparities; "race" and "ethnicity" are widely cited as factors in such disparities. Yet what do these terms mean to those who do the research on health policy?

The students in my graduate class, Ethnicity and Health Care, set out to study that question. Working with groups interested in these issues at two health research institutions, 74 researchers were interviewed using an open-ended protocol. Topics included demographic information; definitions of diversity, race and ethnicity; perceptions of the role of these and other factors in health disparities; experiences with cultural competency training; and opinions about the utility of census categories in health research.

We reached some interesting, perhaps surprising conclusions; race was considered by the interviewed researchers to be genetically-based, and not distinguished from ethnicity. Ethnicity was understood as related to culture and important in interaction with patients and

program design. Thus, culture (interpreted as a barrier to healthy behaviors) and ethnicity are genetic to health researchers, who therefore do not consider cultural competency training to be useful.

My students and I saw the root of the conceptual confusion in the education of health professionals, and recommended that training of health professionals, researchers and undergraduates include training in the sociocultural concepts of culture, race and ethnicity.

Our findings are resulting in changes at one of the institutions. The findings will also be published with the whole team as co-authors.

This project contributed to the students' learning of research and its methods in ways different from traditional types of graduate classes in applied professions like public health, as my students commented.

One student, trained as a physician in Ecuador and studying for a Masters of Public Health at the University of South Florida said, "[It] is one of the most exciting courses that I've had, not only because of the anthropological perspective of the 'health system,' which I think is hardly ever mentioned in public health and specifically 'global health' but because of the 'hands-on-practice' experience.

Comments from other students included: "I anticipated that the [researchers] we surveyed would try to provide the most politically correct responses that they could muster. ... I did not

anticipate how many would consider race to be a construct with a physical, genetic meaning. ... In terms of the class structure, I think the best experience a grad student can get is real exposure to conducting research. Many new PhDs have no idea how to develop an assessment tool, how to conduct random interviews and how to code or analyze the data. It was also valuable to work as a team!"

"What I liked best and benefited most from our class project [is] how the project prepared me to do research in the real world ... We went from having an idea to developing the research question and design, drafting the instruments, conducting interviews, collecting, analyzing and reporting on the data. You can read all of the books on conducting research that you want, but nothing substitutes for actually working through each step of the process."

"For many reasons, this was one of the most valuable classes I have taken at USF thus far. It provided a rare opportunity to interact with high-level researchers, ... to collaborate with both students and faculty, and to focus on an issue that has extensive health policy and health research implications."

On the basis of this and previous experiences, I strongly recommend courses of this type for graduate students, and in particular, for those in applied programs. ■

Roberta D Baer is professor of anthropology at the University of South Florida. The students in the applied anthropology course described here included: Erika Arteaga, Karen Dyer, Aimee Eden, Rosalyn Gross, Hannah Helmy, Margaret Karnyski, Doug Reeser, Airia Sasser and Emily Wright.