

HOT STONES AND COLD RICE

By Rose Jones

I spent a little more than a year living on a small island in the West Indies during the late 1980's, collecting data for my doctorate on sex, reproduction and sexually transmitted infections (STIs). It was a very interesting time and place to be conducting sex research. Cultural and biomedical knowledge on HIV/AIDS was still in its infancy and misinformation on sex and sexuality was rampant. Indeed, Haitians were still thought to comprise a culturally unique risk group for contracting AIDS when I began my fieldwork.

As soon as I arrived on the island, I set up residency in a rural village on the outskirts of town and slowly began to settle into the daily rhythm of island life, learning *Patwah*, the local language, working side by side with women in the banana fields, carrying water on my head from the community standpipe, and learning to cook the local staple, *lachay* and figs, boiled pigtailed and green bananas. I also began to travel around the island with a French physician as he made weekly visits to makeshift STI clinics. As patients waited to see the doctor, I interviewed them about their understanding of STIs. I was amazed, in only the way that a naive and overly zealous graduate student can be, to hear patients accurately recount the biomedical facts associated with the transmission of HIV. Time after time, patient after patient, village after village, the doctor's patients told me that AIDS was transmitted by dirty needles, prostitutes, and from mothers to babies. This offered a striking contrast to what I was hearing in the village. In the evening, under the protective hands of women braiding my hair and the safety and sanctity of the *Patwah* language, I learned that AIDS was transmitted when men secretly put holes in condoms, when people sat on hot stones, or when they ate cold rice. I learned that young boys having sex with older men were not at risk for contracting AIDS because they were *kokods*, virgins, according to island norms. I learned that women were *jameses*, or prostitutes. And, I learned that the French doctor was *dek-dek*, stupid, and did not know anything about STIs.

The information the doctor's patients relayed to me at the clinics had been acquired through public health campaigns designed to educate islanders about the impending AIDS pandemic. Although the information was accurate and patients were able to correctly recall it when prompted, it was completely disconnected from the reality of their lives. The knowledge that dirty needles constituted a risk factor for contracting HIV was essentially meaningless. Intravenous drug use was virtually unknown on the island and it was all but impossible to even obtain a hypodermic needle.

By contrast, the information I acquired in the village came from the reality of peoples' lives. It was embedded in the intricacies of the gender system and mediated by a complex constellation of beliefs and behaviors rooted in humoral pathology, magico-religion, and structural relations. *Kokods* were considered virgins because they had not yet established viable reproductive relationships, not because they were sexually inactive. Indeed, many of the *kokods* I knew had frequent, unprotected sex with older men and young women, but by island norms, they were classified as virgins, sexually inactive. It was the economic alliance established through reproductive ties that determined sex status, not the sex act itself. Similarly, women

were referred to as *jabetes* because of the complex ways in which social and economic resources were exchanged between men and women. They were not commercial prostitutes. The French doctor was stupid because he was frequently observed sitting on the hot steps of the local church - a widely understood risk factor for contracting an STI. In spite of my pleas, the doctor refused to sit under the shade of a tree even as his patient load dwindled to near zero.

Research would eventually demonstrate that successful AIDS interventions, like all public health campaigns, can only be achieved when culturally grounded; when messages are connected to the reality of people's lives and embedded in the political and economic framework that structures their lives. It was easy for me to understand this connection, to see how my ethnographic work was relevant to problems in public health. It would, however, take me many years to understand how my ethnographic work was also relevant to problems in medical education.

After completing my doctorate, I took a faculty position at a large medical school in Texas. As an ethnographer, I focused on settling into the cultural rhythm of academic medicine, learning Medspeak, the technical language used by clinicians, attending Grand Rounds, participating in journal clubs, lecturing, supervising community preceptorships, and conducting research. I also began rounding at the teaching hospital, observing small groups of students, residents, and attendings as they engaged in the daily ritual of patient care. I was perplexed to see how the dynamics of culture played out at patients' bedsides. I saw students readily apply the concept of culture to patients who presented with pica or *empacho* or *susto*, but fail miserably to make cultural connections when patients' narratives deviated from learned cultural scripts. I saw students label patient interactions as "cultural" when the patient was Korean or Mexican or when they did not speak English, but remain oblivious to cultural dynamics when the patient had the same skin color or spoke the same language that they did. I saw smart, well-intentioned, residents become frustrated and confounded when patients distorted the boundaries between biomedicine and ethnomedicine, contextualizing their illnesses by moving rapidly and fluently from hypertension to bad blood and from cold rice to childbirth. I also saw attendings spend inordinate amounts of time repeating jargon-filled explanations of complicated diagnoses, controversial protocols, and clinical outcomes to patients and family members who were not conversant in Medspeak. Time after time, patient after patient, ward after ward, I saw students and physicians unwittingly struggle to be culturally informed and challenged to become culturally engaged.

The students and physicians I rounded with were drawing on the cultural knowledge they had acquired in medical school and through Continued Medical Education (CME) coursework. This cultural knowledge did not reflect the realities of clinical medicine. It derived from a cultural paradigm that was embedded in a biomedical curriculum that was explicitly designed to address the bio-physiological dimensions of disease. The cultural knowledge that students learned was disconnected from the way patients experience illness and removed from the way patients convey these experiences to physicians. It was also disconnected from the way physicians are taught to retrieve and process information they elicit from patients. Like the islanders who mastered risk factors for HIV that were disconnected from the reality of their daily lives, I soon came to understand that physicians were mastering cultural knowledge that was disconnected from the reality of their clinical lives. In both cases, the result is the same – meaningless messages, useless interventions, and ineffective outcomes.

It has now been many years since I left the island and rounded with that first group of students and physicians. I have gone on to conduct other ethnographic studies on different

islands and I have worked with numerous providers in many types of clinical settings. I have seen culture become codified, certified, standardized, and mandated. I have seen new cultural paradigms emerge and fade away and I have seen community and global preceptorships integrated into medical education. I have not, however, seen any real change in how culture is positioned within the medical curricula or how it plays out in the hospital or clinic. Culture remains, where it has always been, stuck at the very edges and margins of medical education, floating in and out of importance and favor, as the precarious cycles of funding and political agendas dictate.

There is, of course, no magic bullet to solve the culture problem in medical education, no quick fix or neoteric paradigm to save the day. The culture problem is, like human behavior, complex, multi-layered and dynamic; a one-size-fits-all solution is simply not possible. The culture problem is not about the acquisition of cultural knowledge or the precision by which it is executed at patients' bedsides. It is inherently about relationships. Somehow the boundaries that separate physicians from patients have become too rigid and fixed. Separated by the vernacular and technical languages they use to communicate with each other, alienated by the biomedical and sociocultural discourses they use to conceptualize health and illness, and divided by deep social and economic power differentials, physicians and patients have become disconnected from each other in critical ways, in ways that make it difficult to become culturally engaged. Through my fieldwork on the island and in the hospital, I learned that authentic cultural connections are only possible when the lines that separate "us" from "them" are fluid and malleable. For this reason, I always remind my students not to sit on hot stones or eat cold rice.

Rose Jones, who has a PhD in Anthropology from Southern Methodist University, has been actively engaged in medical education for more than two decades: teaching, writing curricula, conducting research, and lecturing. Dr. Jones has held faculty positions at UT Southwestern Medical Center, Parkland Health and Hospital System, and Children's Health at Dallas. Her areas of expertise include cultural competency, health literacy, community advocacy, and ethnographic assessment. She has conducted research in diverse settings, including Mexico, Jamaica, St. Lucia, Barbados, and East Texas. Dr. Jones is currently the Director of Evaluation at the Perot Museum of Nature and Science in Dallas.

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