

**UCLA**

**UCLA Electronic Theses and Dissertations**

**Title**

Constructing Competent Care: How Physicians' Self-understandings Inform Notions of Expertise

**Permalink**

<https://escholarship.org/uc/item/3jv157j3>

**Author**

Merritt, Carolyn Rebecca

**Publication Date**

2015

Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA

Los Angeles

Constructing Competent Care:

How Physicians' Self-understandings Inform Notions of Expertise

A thesis submitted in partial satisfaction of the  
requirements for the degree Master of Arts  
in Anthropology

by

Carolyn Rebecca Merritt

2015



ABSTRACT OF THE THESIS

Constructing Competent Care:

How Physicians' Self-understandings Inform Notions of Expertise

by

Carolyn Rebecca Merritt

Master of Arts in Anthropology

University of California, Los Angeles, 2015

Professor Linda C. Garro, Chair

Social scientific scholarship on clinicians' and patients' roles in medical treatment has emphasized the importance of exploring patients' lifeworlds in understanding their unique contributions to intersubjectively constructed narratives of healing. Such work has often neglected similar variation in physicians' subjective perspectives and experiences, however, that likewise imprint this caring relation. Using a narrative analysis of case material gleaned from extensive life-history interviews with two physicians who specialize in treating chronic vulvar pain, or vulvodynia, to illustrate the clinical perspective, I examine how physicians' articulations of their unique treatment philosophies are tied to their broader life narratives and worldviews. I argue that attending to the ways in which physicians' conceptions of self are imbricated with their clinical engagements can help illuminate the dynamic interplay between individual and

cultural meaning systems in each physician's philosophy, and in so doing, add to current understandings of how notions of biomedical competence and expertise are constructed. I also suggest that variations in clinical approaches rooted in the valuation of differing relational styles, which in turn are attached to variable understandings of ideal personhood and patients' roles, may have important consequences for patients as physicians imprint the intersubjective construction of narratives of illness and healing.

The thesis of Carolyn Rebecca Merritt is approved.

Douglas Hollan

C. Jason Throop

Linda C. Garro, Committee Chair

University of California, Los Angeles

2015

## Table of Contents

Introduction.....	1
Background.....	3
Methods.....	7
Analysis.....	9
Tracing understandings of expertise and competent care in different relational styles.....	9
Narrative thinking at the intersection of self-concepts and notions of competent care.....	16
Understanding patients as persons: potential effects of physicians' notions of competent care.....	34
Concluding comments.....	42
Appendix: Transcription guide.....	46
References.....	47

## Acknowledgments

This thesis has taken shape as a result of the personal and academic influences of many people who have invested their time, care, and expertise in me. I am indebted to each of my committee members for the rich nourishment they have provided during the last two years through personal communication and in graduate seminars, which has deeply impacted my intellectual development and personal growth. Linda Garro has shared her remarkable talent for distilling what seemed most conceptually relevant and exciting in the ideas I brought to her and helping me focus, situate, and phrase them more concisely than I could have on my own. Doug Hollan has helped me navigate a continually developing sense of “what really matters” in terms of how I approach pursuing work that feels meaningful to me. Jason Throop has been generous and insightful in introducing me to numerous lineages of ideas that have proven very fruitful. In addition to the attitudes of overwhelming positive support that each of them have shared with me, they all have and continue to, simply in being themselves, provide incredibly inspiring examples of the possibilities that open up when one chooses to devote one’s energies to scholarship, writing, and teaching in the field of psychocultural and medical anthropology.

I also could not have completed this thesis without the support and encouragement of my friends and colleagues at UCLA. I am grateful to my entire cohort, especially Abigail Mack, who listened to numerous iterations of my evolving ideas over coffee and walks, as well as Rosalie Edmonds, Alex Thomson, Dalila Ozier, Gwyneth Talley, and cohort-cousin Addie Shrodes, who were all writing their theses at the same time and at regular intervals shared both the excitement and frustration that comes with undertaking such a project. Scarlett Eisenhauer and Claudia Huang also both generously offered to read drafts of my writing, though I never ended up being quite organized enough to afflict them with this. My roommates, Jananie Kalyanaraman and

Kathryn Cai, provided unfailingly and overwhelmingly warm support and invaluable doses of humor, along with occasional resuscitation when it was needed after long bouts of working. My dear old friends, Sarah Kurz and Anna Ehrlich, have been rooting for me since long before I moved to California to pursue my graduate education, and their interest in my pursuits and belief in my abilities continues to mean so much. So many other friends and acquaintances inside and outside of the department have also cheered me on, whether directly or not, and I appreciate their presence in this process.

My family members – especially my mom, Jenny, stepdad Richard, dad Steve, sister Jaime, and grandma Charlotte – have been such an important source of support for me as they have engaged in the effort of understanding what it means to me to study anthropology. Their listening to my evolving ideas and experiences has helped give shape to this journey.

Finally, I would never have been able to write this thesis, in part because I would never have come to hatch the core idea at all!, without the trust, generosity, and openness of the physicians that I interviewed for this project, whom I call Helen and Donna. I was, and am, amazed and pleased that they ever agreed to the somewhat crazy idea of sharing their life stories and personal experiences with a naïve anthropologist whom they had never met. Not only was what they shared with me truly exciting for academic and analytical reasons, but learning about their philosophies on life and care made a deep impression on me, and I among so many others am grateful that they have built their professional and personal lives around caring for people in pain and in need and working tirelessly to advocate for what they believe in.

## **Introduction**

Social scientific scholarship that explores clinicians' and patients' roles in medical treatment has emphasized the importance of exploring patients' lifeworlds in understanding their unique contributions to intersubjectively constructed narratives of healing (e.g. Mishler 1984, Mattingly 1998, Charon 2006). Such work has often neglected similar variation in physicians' subjective perspectives and experiences, however, that likewise imprint this caring relation. Although numerous authors have acknowledged individual differences between clinicians, pointing to the heterogeneity within biomedicine, such token gestures seem to outnumber the research projects that have taken up this variation as an explicit object of study. I hope to show that a more nuanced attention to clinicians' lives can further illuminate how different ideas of competent care come to be constructed as physicians build expertise in ways that resonate with their personal sensibilities and experiences.

As North American medical anthropologists took up studies "at home" which had formerly been the realm of medical sociologists, and began to see biomedicine as a legitimate fieldsite, scholarship emerged that suggested how rich and illuminating research on individual physicians might be in terms of understanding how philosophies of medical care are constructed (e.g. Hahn 1985). This research generated a number of fascinating questions which remain relevant in the contemporary academic arena amidst a recent proliferation of interest in medical anthropology on care (e.g. Gammeltoft 2014, Han 2012, Nakamura 2013). During the anthropological turn toward the study of biomedicine, Margaret Lock wrote that that "general statements about the beliefs and praxis of the medical profession, or even segments of it, cannot be made...[because] individual physicians are inclined to work from folk models which form the basis for their decision-making...These models should be the objects of close ethnomedical

analysis in order to do justice to their complexity” (Lock 1985:135). I suggest that individual variation in physicians’ investments in particular explanatory frameworks within shared cultural settings is an important dimension undergirding the complexity of such models. Examining physicians’ personal accounts of themselves and their compelling concerns in concert with their practice models is one way to begin the further investigations for which Lock calls.

Writing contemporaneously with Lock, Mary-Jo Good (1985) encouraged the anthropological examination of discourses on physician competence, with an eye toward the various layers of meaning such discourses may index. In her words, “Analysis of the discourse on physician competence reveals the complexity of these structural situations [in the medical community] and of the cultural and personal systems of meaning in contemporary medicine” (M. Good 1985:265). I contend that a comparative approach that seeks to critically examine differences between individual physicians’ views of their practices and models of expertise can shed new light on these rich areas of study, highlighted above, that began to be probed early on in studies of North American biomedicine. Specialists in ambiguous conditions such as functional chronic pain are particularly apt respondents in such a contrastive project, as a great deal of variation in their clinical approaches often follows from a sparse evidence-base and lack of centralized treatment recommendations.<sup>1</sup> Given that physicians treating poorly-understood conditions have fewer standardized resources from which to draw their medical ‘evidence,’ each specialist may leave quite a unique imprint on the patient’s healing experience, patterned on the

---

<sup>1</sup>While variation in clinical strategies associated with physicians’ individual investments and worldviews may be especially visible and potentially more-wide ranging in the arena of ambiguous illness, I do not intend to claim that the usefulness of this approach is limited to ambiguous conditions. Other scholars have pointed to how crucial attention to variability or multiplicity may be even for conditions with relatively clear pathophysiological correlates, such as Annemarie Mol’s (2002) writing on the enactment of atherosclerosis. In addition, scholarship illuminating the ideological work involved in the standardization processes of evidence-based medicine, and the wide variation in investment in, modes of use of, and understandings of the value of the evidence base shows that such problems are in no way irrelevant for conditions that are framed as well-understood within the medical literature (Timmermans and Berg 2003).

modes of seeing, hearing, speaking, and relating that he or she individually sees as being most important in providing competent care.

Using a narrative analysis<sup>2</sup> of case material gleaned from extensive life-history interviews with two physicians who specialize in treating chronic vulvar pain, or vulvodynia, to illustrate the clinical perspective, I take up Lock's and Good's projects, examining how physicians' articulations of their unique treatment philosophies are tied to their broader life narratives and worldviews. Attending to the ways in which physicians' conceptions of self are imbricated with their clinical engagements can help illuminate the dynamic interplay between individual and cultural meaning systems (D'Andrade 1984) in each physician's philosophy, and in so doing, add to our understanding of how notions of biomedical competence and expertise are constructed. Variations in clinical approaches rooted in the valuation of differing relational styles, which in turn are attached to variable understandings of ideal personhood and patients' roles, may have important consequences for patients as physicians imprint the intersubjective construction of narratives of illness and healing.

## **Background**

Introducing their 1985 volume, "Physicians of Western Medicine," Robert Hahn and Atwood Gaines wrote that "Recent anthropology...depicts Biomedicine as a 'cultural system', a more or less coherent and self-consistent set of values and premises, including an ontology, an epistemology and rules of proper action/interaction embodied in and mediated through significant symbols" (1985:10; see also Kleinman 1980). Buchbinder (2011) and Kempner (2014), among many others, have vividly illustrated the ways in which hegemonic cultural explanatory resources seep into or even rather explicitly shape physicians' explanatory models.

---

<sup>2</sup> Please see Appendix for a guide to transcription notation.

They highlight, for example, the contemporary currency of brain-based explanations in legitimizing illness experience, even as these explanations may reify disease as being embedded in particular kinds of persons. These studies also illuminate how longstanding culturally-based moral assumptions about the appropriate roles of children, parents, women, and men simultaneously shape perceptions of patients and illness and guide their treatment. Alongside these discussions of biomedicine as deeply culturally-embedded, these authors and others, such as Taylor (2003), have demonstrated that biomedicine continues to be perceived both by physicians and the majority of society as culture-neutral. While revealing in detail how culturally-salient meanings are reflected and reinforced within clinical transactions, none of these works have investigated in depth how or why particular practitioners come to employ the specific cultural/clinical models that they do.

One of the major projects of anthropology more broadly, intertwined with efforts to understand “culture” and “cultural systems,” as dynamic, intersubjective processes, has been to examine how individuals acting in “culturally constituted” behavioral environments (Hallowell 1955) in turn (re)construct their cultural surrounds in complex ways. Examining individual variation provides a crucial engine for this project, yet has had little traction in studies of biomedicine. Rather, studies of the ‘culture of medicine,’ including professional socialization studies (e.g. B. Good 1994), have tended to de-emphasize individual variation among clinicians in favor of a focus on how individuals are folded into a largely unified ideational system. An exception may be found in Holmes, Jenks, and Stonington’s introduction to a collection of articles on biomedical socialization, which indicates that “clinical trainees are not simply socialized and malleable, but are also active subjects who make choices...and use techniques to actively craft themselves internally” (2011:109); yet it is unclear how much attention is actually

given in this collection of articles to *individual* variation in the employment of such technologies of self during professional training, even as patterns in the formation of “clinical subjectivities” are shown to vary across different fieldsites (Holmes, Jenks, and Stonington 2011:106).

The picture is somewhat different when it comes to patients, as medical anthropologists have demonstrated the necessity of attending to how patients’ life stories and individual experiences imprint intersubjective treatment processes. Garro (1994, 2000) examines how cultural models are variably taken up as explanatory resources within patients’ lives, and illustrates how individual patient perspectives and relationships with particular healers mediate culturally inflected understandings as patients make sense out of illness. This work has attended to the intersubjectivity of healing encounters by emphasizing how, in guiding patients’ narrative renderings of their illness experience within a cultural framework, healers may either validate or redirect the perspectives that patients bring to the healing encounter. Further, it has shown how variation in patients’ life histories gives rise to diverse engagements with cultural knowledge that shape simultaneously unique yet deeply socially embedded narratives of healing.

Cheryl Mattingly’s (1998) study of occupational therapy enhanced conceptual foundations for understanding health care as a fundamentally intersubjective process by “examining clinical interventions as transactions between the world(s) of biomedicine and the lifeworlds of patients” (20). Her project took up as well as complicated Mishler’s contention that “the *voices of the lifeworld and of medicine* differ not only in their respective forms of expression, but represent markedly different frameworks of assumptions” (Mishler 1984:171; emphasis mine). Yet in both Mattingly’s and Mishler’s studies, a framing in which the “voice” of “the lifeworld” is the exclusive domain of patients’ experiences and the “voice” of “medicine” represents a seemingly monolithic structure, glosses over variation between physicians within the

medical structure and simultaneously leaves out the possibility of physicians' lifeworlds or personal worldviews entering the physician-patient interaction entirely. Gammeltoft's (2014) and Han's (2012) more recent works echo this imbalance in their nuanced portrayals of practitioner-patient interactions (in the sphere of ultrasound imaging and psychotherapy, respectively) which give a great deal of attention to how patients' individual backgrounds shape their responses to treatment and yet relatively little attention to the individual orientations that underlie practitioners' roles in and reactions to particular treatment encounters. Despite important moves to understand how clinical encounters are deeply intersubjective, practitioners' individual variability has tended to be de-emphasized, and their actions and motives have typically been 'read' through their institutional frameworks.

Garro's (2000) discussion of healers situated in different ethnomedical systems who draw on different explanatory frameworks for illness and Mattingly's (1998) examination of occupational therapists' position above and below others in the professional biomedical hierarchy have provided important starting points for distinguishing the practical consequences of various practitioners' different perspectives for patients. Mary-Jo Good (1995) clarifies another important set of distinctions within the medical world in her examination of female OBGYNs' "feminization" of medicine through legitimizing alternative ways of knowing. Yet even as these pieces highlight variation among sub-groups of clinicians, by the same token, these works have tended to de-emphasize individual variation within such demographic groups, privileging on practitioners' institutionally- or otherwise socially-shaped knowledge and motivations over the personal in the ways they frame and make sense of illness. Without probing healers' lifeworlds, a significant gap remains in our understanding of how practitioners' individual values, orientations, and styles come to imprint the therapeutic process. If, instead, we

resist collapsing physicians' individual perspectives with any abstract social category, we might stand to gain a more nuanced understanding of the unique narrative possibilities that physicians open up as interlocutors in patients' narratives of healing.

Drawing on interviews with two physicians, this paper explores how clinicians collaborate as significant, individual interlocutors in the collaborative construction of narratives of illness and healing as they navigate stances of expertise and competent care in the face of medical uncertainty. I analyze their treatment philosophies concerning chronic vulvar pain, or vulvodynia, by conceptually emplacing their respective medical approaches for this condition within the contexts of their self-reported life-histories and self-understandings.

## **Methods**

These data were gathered as preliminary research for a project focusing on how specialist physicians imbue patients' illness and healing experiences with culturally-grounded meaning. A series of unstructured, open-ended life-history interviews took place over the course of two months in early 2014 with two gynecologists whom I call Helen and Donna. In choosing to specialize in treating vulvar pain fifteen to twenty years ago, both Helen and Donna stood at the vanguard of clinical care for this condition, and even today, the evidence-base for this condition remains sparse, with the extant medical literature reflecting widespread confusion and disagreement among physicians about how to treat and even how to define this problem.<sup>3</sup> Without exposure to any platform of standardized training, the two clinicians in this study have had relatively wide leeway to construct their own understandings of what this condition is and how to address it in the clinic.

---

<sup>3</sup> See the NIH Research Plan on Vulvodynia, published in 2012.

Although Donna and Helen never met, they hold in common the broad circumstances of their lives. Both are secular Jewish women in their sixties who have resided in southern California for more than 30 years, where they received professional training as part of the first wave of female physicians in the 1970s. They both had children while working simultaneously in the obstetrical and gynecologic fields in private practices associated with nationally-reputed hospitals. Within the last two decades, both women also spent significant time and energy developing expertise in treating vulvodynia and saw the number of patients they treated with this condition rise as word spread that they were specialists. A major difference between them currently is that Donna is still in practice, while Helen is recently retired, though still actively involved in professional activities such as attending grand rounds at a nearby major hospital. Ultimately, the interviews highlighted here make clear how differently even two physicians with relatively similar positionality in a socio-cultural frame and within a very small geographical region might conceptualize a given medical condition and its relevance to patients' needs.

Person-centered interviews (see Levy and Hollan 1998) took place at a mixture of home settings, work settings, and coffeehouses, and were recorded and transcribed in full. This interviewing methodology is designed to follow the lead of the interviewee to the greatest extent possible in order to illuminate respondents' central concerns with minimal direction from the researcher. In examining these life histories as personal narratives, I draw on Leavitt's notion that, "[a person's] story is...built around his most centrally powerful and compelling psychological issues. He tells a story that builds an argument about himself for himself, and understanding the terms of that argument is key to appreciating his experience" (2007:81). At the same time, a cost of this approach is the lack of a standardized, one-to-one correspondence between the topics that are explored with different participants. Thus, the data I present here with

regard to both of my informants speaks to fairly organic framings, from their perspectives, of the professional caring work they do and how it connects to their personal lives. Yet because I had no standard set of questions for either of them, the practical sketches and philosophical insights they provide into their work are at times uneven. I do my best, despite this, to analytically compare what may be comparable from their two accounts regarding their approaches to treating vulvodynia.

## **Analysis**

### ***Tracing understandings of expertise and competent care in different relational styles***

Reviewing anthropological work on expertise, Carr explains that “expertise is both inherently interactional...and inescapably ideological” (2010:17). The ethnographic literature she surveys highlights “(a) socialization practices such as apprenticeship; (b) cultural processes of evaluation, validation, and authentication; (c) the institutionalization of ways of seeing and speaking into authorized and authorizing domains; and (d) the naturalization of specified activities as specialized knowledge” (2010:18). None of these ways of framing studies of expertise, however, appear to allow very much room to focus on how individuals within the same epistemological field might build unique models of expertise that draw from and yet do not reproduce more widely shared socio-cultural templates of specialized, competent performance.

Though they share an institutional role, Helen and Donna prioritize different ways of relating when they describe their interactions with their patients. Each of their relational modalities, in turn, is imbricated with individual medical ‘folk models’ (Lock 1985) or ways of interpreting and treating illness. Thus, these different relational styles are tied to their senses of what it means to provide competent care as specialists in their field. Throop articulates that,

“How it is that individuals are...able to engage empathetically with others is a process that is shaped in important ways by particular orientations of the self to his or her world of experienced others” (2008:406). Examples from interview data help illustrate how Helen’s and Donna’s disparate understandings of empathy and expertise might affect their engagements in therapeutic plotment with patients. Both of their strategies can be read as ways to – potentially very differently – collaborate with patients.

Helen’s philosophy of care<sup>4</sup> is undergirded by a fundamental commitment to listening to the patient’s perspective.

**Helen:** Um, I think I had— because— because I married somebody else who also made an income, I had the luxury to decide, okay, **I wanna listen—** need to schedule another appointment for this person to just come in and talk (.) for half an hour. There was no way you were gonna get paid for all that, but **that’s what needed to happen for the thing to be able to really get figured out.**

Tracking the bolded phrases above, we can see that Helen’s approach here stresses the importance of hearing patients’ own explanations as a necessary part of the construction and enactment of her own expertise.

In contrast, Donna sees her own voice as fundamental to achieving positive ends in treatment, and feels most connected with patients and best able to provide effective care when she is speaking to them, rather than listening. Gammeltoft describes how at her fieldsite in Vietnam, “in order to care for their patients, [doctors] had to intervene and guide them in their

---

<sup>4</sup> I do not mean to conflate “care” and “empathy,” as I believe them to be distinct concepts, neither of which is a straightforward or necessarily wholly positive phenomenon. (See Hollan and Throop (2008) for a nuanced discussion of empathy, including widely different cross-cultural understandings, valuations, and uses of empathy as well as its often ephemeral and fleeting quality and its morally ambiguous or even directly harmful potentialities.) For the purposes of this paper, I refer to empathy, generally, as a way of understanding another’s needs, and I use care as it is understood and used by my interlocutors, that is, as a way of providing or facilitating positive intervention and support in processes of healing.

decisions” (2014:121); this same ideology is reflected in Donna’s explanation that women with functional chronic pain are often relieved when she, as the physician, can tell them what they need. Donna’s notion of her voice underlies her philosophy that pain patients who have struggled need to be validated through dialogue about what they are experiencing. This connection is apparent in the following excerpt, where Donna relates how much patients appreciated it when she provided them with information:

**Cari:** So how long of a time do you have to talk with each patient?

**Donna:** At least 45 minutes to an hour. ...

**Cari:** mhmm (.)

So, you let them spend a significant amount of the appointment just telling you (.) stuff that’s—

**Donna:** **I guide it very specifically—**

‘cause I’ve heard meanderings of pain enough.

And it doesn’t help them

and it doesn’t help me.

**I’m pretty focused, in my questions to them,**

**and they are usually incredulous at how right-on we are.**

**And it’s greatly reassuring to them**

that they’re not the first person talking about this.

The different relational and sensory modes that Helen and Donna privilege, above, can in fact be seen to provide the respective bases on which they have assembled unique epistemological frameworks for understanding vulvodynia. In the following excerpt, Helen describes in more detail how her fundamental orientation toward listening illustrated above has been essential for building her clinical expertise:

**Cari:** So then kind of as you started developing an interest in it, more people got referred to you?

**Helen:** Yup. Because very few people knew *anything* about it.

And, I at least found that on the whole, **if you listened to the story, the patients would, you know, generally divide up into two categories.**

**And you could help try and figure out what would work for them based on the two categories.**

And I think that business is still true.

**Cari:** So what were those two categories?

**Helen:** Provoked or unprovoked.

**Cari:** And the treatments would be completely different?

**Helen:** Yup.

**Cari:** Your approach?

**Helen:** Yup.

In the first bolded phrase above, we can see how Helen conceptualizes the patients as doing the work of sorting themselves into different groups; at this stage, she sees her role as not active but rather receptive and perceptive. In the second bolded sentence and below, Helen shows how adhering to this strategy is more than a stylistic preference on her part or a symbolic gesture to gain the confidence of patients, but ultimately is of crucial medical importance. She points to evidence garnered from her own clinical experience that without devoting time to listening to the patient, one risks investing time into a treatment that “doesn’t really work.”

**Cari:** So, in terms of how you would approach, um, starting treatment with patients, was there something you would kind of try first with everyone, and then—?

**Helen:** No, I wanted to hear.

Once they tell you, then they sort themselves into categories.

And, if they’re in one category you’re not really gonna mess around with the stuff in the other one,

**because it doesn’t really (.) work.**

In another part of the interviews, she makes further links between listening and building expertise:

**Cari:** I'm curious about what kinds of things you would present about [at grand rounds].

Like what kinds of interventions,

whether you talked about the importance of listening to people, or—

**Helen:** Yes, yes, yes. That was the *absolutely* most important thing there was.

And it's always been! You know that, right?

I mean, you're a very good listener, so you *must* know it.

That if you just sit there, and **look encouraging**,

[people will tell you **everything you need to know**.

**Cari:** [Mhmm ((*laughs*))

**Helen:** And (.) if you— if you direct that, it's a problem,

and you introduce some sort of bias to it,

and **I don't think you're gonna get the information that you want**.

Here, Helen draws an explicit parallel with the person-centered interview process itself, highlighting the benefits of a mode of pursuing knowledge in which allowing the other to guide the process is paramount if one hopes to gain an emic understanding of the topic, which Helen sees as being the most relevant kind of information for treatment. In Helen's explicit connection between "look[ing] encouraging" as she listens nondirectively in order to draw out the patient's compelling concerns and ultimately ending up with "everything [she] need[s] to know" and "the information that [she] want[s]" in order to proceed with treatment, we can see a double process occurring; on one hand, legitimating the patient's experience of pain through an affective acknowledgment and affirmation of the patient's perspective as valid, and at the same time, funneling this experience into a cognitive model of the relevant medical factors in the situation. Here, then, Helen understands her care to be competent because it is built on the recognition of the primacy of the other. At the same time, a stance embracing open listening can also be seen as

ultimately geared toward the service of medical goals that are decidedly not open ended, but actually fit into a relatively constrained schema held from the perspective of the doctor.

Donna's construction of expertise is also closely tied to her mode of engagement with patients, yet is built upon a different way of legitimating patients' experiences of pain. Her sense of providing competent care is related to her ability to tap into a powerfully affirmative dimension of biomedical reductionism, in which she communicates an acknowledgment to the patient that their pain is "real" by providing a diagnosis linked to specific pathophysiology (see e.g. Baszanger 1998, Buchbinder 2011, Kempner 2014).

**Donna:** Yeah, it took a while to figure that there's something going on here.

But back in the 90s, I started treating patients, um (.)

and then when this [pamphlet] came out I was like delirious because I didn't have to make Xeroxes,

and say, see? Vulvodynia has a name, it's a thing, you're not making it up,

because **people were telling them they were crazy.**

**And that they didn't have anything wrong with them. (...)**

And they would come in and say,

"I think I'm crazy, because everyone tells me I'm fine and I'm in hideous pain."

**So, that's sort of where I got my philosophy that it's a neuropathy,**

**and treat it like it's a neuropathy,**

**and explain it to patients like a neuropathy.**

The first cluster of bolded phrases shows Donna's understanding of the harm done to patients when their concerns are delegitimized, and the second group of bolded phrases reveals how this understanding has been foundational in her adoption of a particular diagnosis that she uses on a regular basis.

The uses of particular medical technologies also take shape at the interfaces of institutional models and personal investments, which provide templates for dealing with patients'

uncertainty and making symptoms intelligible. Helen's emphasis on the care she gives for vulvodynia as being effective because it is grounded in listening, and Donna's highlighting of her own treatment successes as a result of voicing patients' problems, inflect distinct models of competent care which differentially imbue their individual uses of even a very similar treatment protocol:

**Helen:** Um, for people who weren't really quite sure what the heck was going on,  
they really had to keep a diary.  
(...) you just wanted a line for each day,  
**so that you could, um, see patterns,**  
**you as the patient, you as the doctor,**  
**the two of you together can both see patterns,**  
what's working, what's not working.

The bolded phrases above draw attention to Helen's belief that the pain diary is an effective treatment strategy because it allows her – along with the patient – to “hear” or see patterns in the patient's experience. Below, the bolded phrases showcase Donna's explanation of treatment success using a pain diary as centered on her use of it to verbalize and substantiate crucial, helpful insight to the patient.

**Donna:** This is a PMS chart,  
but I use it for all pain patients.  
I just have them put in whatever are their symptoms.  
And plot them,  
(...) **I** can look at a pattern (.) easily,  
and be **able to say** you know, **you think you're not getting better,**  
but last month you had this many black dots  
and this month, [**and they see it.**

Helen's medical knowledge about vulvodynia seems in many ways to be rooted in an attention to the patients' perceptions, while Donna's expertise is based on her own understandings of patients' experiences, and associated efforts to make patients aware of something that already seems clear from her own perspective. These kinds of attunements to patients and their needs in clinical encounters relate closely to interpersonal orientations that suffuse their broader lives, which can be productively illuminated by looking at how they recount their own histories.

*Narrative thinking at the intersection of self-concepts and notions of competent care*

Mary-Jo Good described a "reflective model of discourse" as "a mode of discourse through which physicians reflect on their own skills, limitations, and sense of professional and personal worth" (M. Good 1985:251). This reflective mode, captured well in interviews in which physicians are asked to consciously cognize and express their treatment philosophies, can help researchers and interviewees alike to link "personal experience to professional values, and private meanings to clinical experience (M. Good 1985:260). Applying narrative analysis to the interview data here, which captures some explicit reflections of two physicians on their lives and work, provides a way to begin to trace how it is that their philosophies of expertise have taken shape within and reflect their respective worldviews. Examining several of Helen's and Donna's stories about their earlier life experiences can help us make sense of the divergences in their expert approaches that we saw above.

Phenomenological and narrative analytic modes dovetail usefully when thinking about the dialectic relation between temporality and constructions of meaning (e.g. Ricoeur 1981). Alfred Schutz (1967 [1932]) conceptualizes that life experiences become emplotted in ways that

give rise to ever-expanding meaning-contexts against and within which new information is understood and evaluated. Bruner emphasizes the dynamic interplay between this kind of individual processing and broader social and cultural surroundings, writing that, “We gain the self-told narratives that make and remake our selves from the culture in which we live....we are virtually from the start expressions of the culture that nurtures us. And culture itself is a dialectic, replete with alternative narratives about what self is or might be. The stories we tell to create ourselves reflect that dialectic” (Bruner 2003:87). Hollan’s contribution to these lines of thought from a psychoanalytically informed perspective illuminates the singularity of such a “meaning-context” and sense of self for any individual, no matter how seemingly similar their experiences might have been to another’s. He privileges

a sense of how emotional memories develop over time, linking together different parts of the phenomenal field—people, objects, imaginings—in often surprising, idiosyncratic, nonhabitus-like ways. This in turn provides some insight into why people become oriented to the phenomenal field in the way they do, why they are open if not attracted to certain people, experiences, and ideas, but not so open to, even repelled by others (Hollan 2012: 45-46).

Given that the incorporation of new experiences into individuals’ understandings of self both draw on and also often change their interpretations of their past, it would be fallacious to “read” the reflections and memories reported in interviews as though they accurately represented a continuous accretion of experiences and their meanings through time. Garro’s (2001) writing on autobiographical memory emphasizes the complex, dynamic processes by which personal memories and reflections are formed within cultural contexts and remain open to repositioning and change as new perspectives are gained in the present. “[I]ndividuals remember, drawing on their experiences and knowledge to link the remembered past with the present and to make

projections into the future,” meaning that “remembering is tied as much to current and future concerns as it is to the past” (Garro 2001:122). Thus, it is apparent that there is no simple linear trajectory along which experiences “feed forward” into the future, nor can memories in the present be used to trace a path backwards which shows any simplistic connection between the present as emerging out of the past. However, it is significant that individuals recounting their pasts nevertheless do highlight exactly these kinds of felt connections between past and present in spite of the fluidity and flux of memory processes and the complicated ways these memory processes relate to lived experience. Describing the narrative framing of experience, Garro writes,

Narrative thinking draws attention to how jointly cognitive, cultural, and social processes offer potentialities for organizing and endowing experience with meaning...schemas are active organizations of past experience that mediate our ongoing transactions with the world. As Hallowell first pointed out, our worlds become culturally meaningful worlds in concert with the development and attunement of orientational frameworks (namely schemas) for selectively attending to and organizing experience in those worlds (2007:62).

Self-reported life histories can thus afford a preliminary way to trace how physicians’ disparate medical logics are equally intelligible when situated in relation to the same physicians’ reflections on their personal engagements with broader cultural trends. I suggest that just as individuals’ recountings of personal experiences and conscious articulations of their worldviews tend to center on their most compelling concerns (see also Kleinman 2006, Leavitt 2007), so too are the ideologies of competence and care that individual physicians employ in the clinic centered on their compelling concerns. Variation in physicians’ understandings of and strategies for treating chronic pain indicates that even as widely shared, socio-culturally grounded

meanings serve as important clinical resources in the face of medical uncertainty (e.g. Buchbinder 2011, Buchbinder n.d.), distinct ways of relating to prevailing cultural models may significantly color how individual physicians construct expertise. In other words, exploring where personal and cultural understandings of “what really matters” (Kleinman 2006) converge in their own histories can illuminate the epistemologies that scaffold physicians’ clinical models.

One important starting point for the present analysis is to explore the settings from their personal pasts that clinicians identify, more or less explicitly, as being relevant in understanding illness in the present. Ochs and Capps (2001) emphasize the importance of narrative settings in giving meaning to unexpected events, explaining that narratives

contain settings that provide circumstances, frames of mind, and background information relevant to making sense of the central narrated incident...[and that s]ettings have the potential to go beyond simply contextualizing events—they may explain them as well.

They may, for example, introduce certain understandings and values (130).

I posit that my informants, Donna and Helen, have built their expertise in relation to deeply embedded, lived and remembered ‘settings’ that combine cultural and personal models for understanding their own and others’ struggles. Helen’s and Donna’s own narrative framings of their lives, including their explanations of the goals that have motivated them to pursue specific opportunities and the aptitudes that allowed them to conquer challenges that arose, have led to different conceptions of the ‘problem’ underlying vulvodynia, and hence different ideas about how to best reach toward a ‘solution’.

Drawing on these ideas and on Garro’s notion that, “[t]elling about a past event allows us to relay what matters to us and to impart how an event takes on meaning for us” (Garro 2001:120), I use the settings of Helen’s and Donna’s own life stories, as they understand them, as one way to explain how they come to interpret and respond to the symptoms they see in the

clinic in the ways that they do. Both Helen and Donna described their lives as having had very straight trajectories, and their descriptions of what they distill as their core motivations from early on reveal important clues about what kinds of broader settings they draw on to make sense of their own experiences and roles, including how they interpret ambiguous symptoms in the clinic. Here, I suggest several ways in which these differences in framing can be traced to their different treatment philosophies, strategies, and styles described above; below, I explore some potential implications of these differences for patients' understandings of their own experience.

Helen takes for granted, and makes explicit, that the “setting” or larger social context in which she came of age (“the sixties”) shaped her own and others' ways of being in the world:

**Helen:** You know I think it still all has to go back to the sixties, and I'm—

**I'm sorry, to be a basic boomer, but you know**

**whenever it is that you come of age, that's when the world sort of begins for you (...)**

Um, and, there didn't happen to be a major world war going on at the moment.

So, therefore, **we** had the luxury to go,

“Well, okay! So now **we're** at an okay level, **can we make this better?**”

And, so that's when **you started to see**, well, **how come the black people don't get to vote?**

Well, you know, **how come there— women are just staying at home giving Tiki parties?** (...)

Uhh, I mean, a glass ceiling? I thought it was a cement one. (...)

The idea was, that **we wanted to have a country that was more representative of what the country was.**

So that it wasn't that, uh, the only people who did anything of any concern or interest were

white males between this age and that age.

In describing herself as a “basic boomer,” she positions herself as a member of a group (“we”) with what she posits to be a strong base of shared characteristics and seemingly unanimous motivations to “make this better.” In each of the passages above, Helen highlights and reinforces a culturally-situated self-definition (e.g. Bruner 2003:87) of being driven by a need to cultivate

an awareness (“start to see”) and skepticism (“how come...”) of the social constraints under which other people lived, with an end goal of helping others and bringing equality about (“hav[ing] a country that was more representative”). She gives specific examples, such as the story below, of times when she stepped in to fight discrimination against a group (“those guys”) that she herself did not belong to, but felt solidarity with (“actually hung out with [them]”):

**Helen:** There used to be a dress code in high school and (...) um, guys had to wear pants, and they had to have hair that was a certain length, uh-huh (.) really.

Well, you know, now it was 1966, and so the Beatles had already gotten here, blah blah blah, so not surprisingly, guys were starting to grow out their hair. (...)

And, so, the vice principal of our high school, really, really had a problem with this and he was a football coach. (...).

And, he got some of his team players to go beat up the boys who had long hair.

And, **that didn’t sit well with those of us who actually hung out with those guys,** and so, therefore there was a march on the administration building having stolen from the school, the fife, the drum, and the flag. (.)

Uh, to basically insist that this is not fair (...)

Although Donna also grew up in the United States during the same time period as Helen, and also grounds her overarching life story in a historical, feminist-inspired consciousness, this setting holds different meaning for her. In contrast to Helen’s consistent framing of others as the underdogs for whom she was in a position to provide help, Donna makes stories about the urgent necessity of advancing her own and her group’s opportunities and capabilities within this milieu central.

**Donna: It was in the mid ‘70s that I was in medical school, and it was a very misogynistic time.**

So it was bucking the system to go to medical school.

**And a lot of flak was received because of that.**

**Cari:** Yeah. Were there specific experiences you can remember where—

**Donna:** A litany, but I don't think that's the project, you know,

I could go on and on and on and on, but, you know,

a few of them were that, there was no protection, uh, for discrimination,

so they were allowed to discriminate, and they did.

So, in, uh, my medical school, you had to take call to learn certain things at night,

and when we attempted to use the call room we were told that

men didn't like that women were using the call room too.

So we wouldn't use it, so their solution in the medical school

was not to have women at the university hospital.

We'll just send you to another hospital where they have more facilities.

**And we rejected that.**

**So it was a battle.**

It's like, really?

You think that's a reasonable alternative?

You just say we won't have women do surgical specialties at the university hospital?

'Cause that doesn't sound reasonable to me.

In this and other stories, Donna foregrounds her own, and members of her own group's, vulnerability to social discrimination ("a lot of flak was received"), and recounts how she and her cohort perceived responded to these attacks ("we rejected that"; "it was a battle"). The following passage reflects Donna's conscious concern with fighting for issues that concern herself directly, even as her actions may also have positive effects for others in similar situations.

**Cari:** So, it sounds like you have had a very tough skin through all of this (...)?

**Donna:** You know, I'm actually not sure that I have a thick skin,

I'm sure that I have a high determination factor.

I'd actually think a lot of these things affected me,  
and I was very sensitive to them,  
but I was determined not to let people thwart me or get in the way.  
I mean, the physician that I told you, who (.) um, helped me see all the surgery at [name of hospital],  
I asked him for a recommendation for medical school,  
and he initially refused,  
'cause he didn't think women should be doctors.  
And, I had to argue with him to give me a recommendation. (...)  
Um (.) so **I don't think I'm that thick-skinned,**  
but I don't— **in some zones, I won't take no for an answer if it's truly unjust.**  
In other ways, live and let live,  
**I'm not fightin' every battle. (.)**  
**And I'm not fighting everyone's battle.**

Donna makes clear here that in “some zones,” when “it's truly unjust,” she is willing to fight for change. The phrasing conveys an ultimate concern with discrimination that has directly impacted her own experience by limiting her opportunities and plans, which is emphasized by her declaration that she is “not fighting everyone's battle”. This differs significantly from Helen's reported attunement to and investment in the constraints faced by many various ‘others’.

Throughout their interviews, both Helen and Donna framed problems and their solutions, for which they designed goal-based efforts to intervene (see Ochs and Capps 2001:172-3), as being born out of a historical and emotional-motivational backdrop in which they saw misogyny all around them. As individuals, however, they had different ways of relating to the same larger cultural surrounds at this time; what made the life projects that arose for them out of this milieu personally compelling, and the way they framed these endeavors, were distinct. Here, we can see the interface between the personal and the social-cultural in establishing relevant

settings for interpretation. Going back even earlier, to memories of younger childhood, can help uncover the divergent orientations with which Helen and Donna approached later scenarios of misogyny as they set out to work as health care providers for women.

Below, I explore thematically linked series of Helen's and Donna's vignettes, respectively, to show how the memories they frame, retrospectively, as being representative of their own attunements from early childhood carry through to why they chose obstetrics and gynecology as a specialty. Then, I tie these and other relevant passages from their personal lives to their own understandings of what makes the care they give for vulvodynia particularly competent, qualifying them as specialists. In this choice of career, both Helen and Donna emphasized that the misogyny of the time was a deciding factor; however, the ways in which they conceptualize this decision align with their respective narratives of self, highlighting the different motivational contexts that they foreground. Likewise, the way that each has come to hone specialized skills in treating vulvodynia reflects the different commitments they have cultivated throughout their lives.

Remembering the existence of a strong drive to build and follow a clear path for herself from her earliest years, Donna recounts that as a young student:

**Donna:** I pretty much stuck to the rules,

I'm very much a straight-arrow with a **laser focus**

and I kinda saw my life as a black box,

**if I worked hard, I would keep on the track and get to where I wanted to be.**

With a pretty direct route.

So I was a hard-working student in elementary school and I did well.

I would argue a principle to the death. (.)

In eighth grade, **I argued with my science teacher** because I had—

he gave extra credit for tests, and I had (.) over a hundred on all the tests,

but in my notebook, he gave me an 80. (.)

And I argued to him that a notebook is a study aid,

and that if it was working for me to get a hundred and four on the tests then it was a perfect notebook.

**And he reneged.**

Later in the interviews, she describes her reason for choosing OBGYN as a specialty:

**Donna:** I went into it [OBGYN]

‘cause I liked women’s health,

and because the patients were accepting.

So when we went through all of our rotations as students,

m— often, the— the patients would say, “*You’re my doctor?*” (*puts on a voice*).

And, “*You’re the student?*”

You know, they really gave you a lot of pushback for being a woman.

But on the OBGYN service, the patients loved it.

And on pediatrics they didn’t mind.

But that did not appeal to me at all.

Internal medicine appealed to me,

and I was initially applying for training in internal medicine.

But somehow along the way, **I changed my mind.**

And some of these were the issues that when I did all of my interviews,

they were so unpleasant (.) I said I never want to do another interview for the rest of my life.

So I’m putting the fir— the four-year programs first and second.

**So the misogynistic issues (*slight chuckle*) affected my choice a bit in that way.**

**I just didn’t want to go through that process again.**

When looked at in combination with the anecdotes further above in this section, we can see from these excerpts that Donna values an image of herself in which she has always been highly goal-driven, and keenly attuned to the situatedness of her own goals within a larger web

of sociality. She has carefully prioritized where to direct her efforts in order to preserve her fortitude (recall from a passage above, “I don’t think I’m that thick-skinned” and thus “I’m not fightin’ every battle”), speaking at times throughout the interviews of being drained by the advocacy work she did, saying that it “comes with a cost” and “takes a piece o’ ya”. At times, she has made adjustments to her goals, and she explains both her triumphs and these compromises in relation to external factors, which have often taken the form of discrimination by men. In the way she tells how she reached her choice of specialty, she highlights the importance of *herself* being accepted by her patients, as a way for her own goals to be facilitated, rather than the other way around. This is further reflected in the following excerpt, in which she elaborates on a basic cornerstone of what she sees as making her a vulvodinia expert – a knowledge of which medication to use and when.

**Donna:** [T]here are a lot of things **we can do**.

And **I wanna get rid of the pain as soon as possible**.

And it can take months, so **we might as well start the medicine on day one**.

And if you’re gonna refuse to take medicine, after you’ve seen **all these other doctors**,

and the problem isn’t getting better,

then maybe I’m not the doctor for you.

‘Cause **we need to do something together**.

This passage, above, illuminates how Donna’s orientation toward others shapes her role as an interlocutor in the intersubjective process – in which “we can do...we need to do something together” – of ‘clinical emplotment’ (Mattingly 1998). In saying, “we might as well start the medicine on day one,” she fuses her clinical decision with the patient’s action, leaving no room for disagreement or negotiation. Her claim to expertise, which she juxtaposes to the lack of success of “all these other doctors” who have previously been unable to help her patient, is

rooted in the notion that “[she] want[s] to get rid of the pain as soon as possible.” At first read, the use of the word “together” in this instance may seem as though it leaves room really only for herself, further probing may reveal more complexity here in the relationality being imagined. Donna emphasizes that she is not interested in fighting the patient’s battle for them (as she said above: “I’m not fightin’ *everyone*’s battle”). She is also not interested in fighting against them or making them engage in treatments that they truly do not want, indicating that if this were the case, “then maybe I’m not the doctor for you.” She does, however, see herself as deeply invested in fighting *with* them, if they are open to joining her, in a way that will benefit them at a truly deep level. I contend that she sees the possibility for true alignment here, wherein the patient will actually experience a perspective shift rather than simply going along with her prescriptions, through stories she recounted about times when those who had initially not agreed with her eventually came around. In the following vignette, she remembers her reaction to being bypassed for a promotion in favor of a man:

**Donna:** I said, “Well, that’s the definition of discrimination.

When you choose someone who looks like you and acts like you, um (.)  
to the exclusion of someone more qualified.”

To which they all said, to my face, “No, we’re not sexist, we could never be sexist. We’re just not.”

And I said “**You’ll think about it.**”

And I was furious.

And again, a couple of months later, one of them came back to me, and said,

“I discussed it with my wife and she told me I was a sexist.

And I looked at the definition and **you were right.**

And I’m really sorry, and **I get it.**”

Such experiences give Donna a firm basis to believe that (a) she is right to stick by her convictions of what she sees as right or worthwhile, such as a given treatment protocol that she has used with many patients, even when others question her judgment and that (b) if they really “think about it,” patients might similarly come to see in a fundamental, embodied way that she was right about treatment, that they would “get it” and appreciate that she had shared what she knew.

A similar anecdote, below, sheds further light on the complexity contained in how Donna navigates caring for others, and on how the role of her voice and speaking to others in giving this care is fundamental, in contrast to Helen’s listening-based approach. She recalls a difficult time for her daughter, and describes how her daughter finally started to feel better:

**Donna:** So last spring I said to [my daughter], “Well, I guess you have two choices.”

And she said, (.) “Yeah, I don’t like this.”

I said, “Yeah,” ‘cause I’d been telling her for three years that

she should probably treat these issues and then I stopped,

‘cause it wasn’t working, cajoling her, paying her off didn’t work, nothing worked.

So, n’ I learned my lesson, and **I just shut up, and all I said** to her last spring was,

I said, “You have two choices, you can listen to the voice in your head and be stuck, or you can deal with it,”

and that finally rang true to her and she went to see someone

and got treatment for these issues

and **she’s a different person now.**

So, you know, **she had to figure it out herself.**

Even when, in Donna’s view, she refrained from projecting or imposing anything onto her daughter, (“I just shut up”), we can see that engaging as a vocal interlocutor remains central to her helping strategy (“all I said...I said”). We also see how this approach becomes positively

reinforced within the relationship, when acting on this philosophy once again proves fruitful, not only for herself, but for the person she cares for. Interestingly, Donna remarks that her daughter “figured it out for herself,” a gloss, also, for enacting agency, by acting directly on Donna’s advice – potentially blurring a clear distribution of power in this caring relation.

Returning to my earlier discussion in the section on expertise of Donna’s notion that it is both more efficient and effective to reassure patients by explaining to them what is going on rather than listening to what she calls their “meanderings of pain,” we can understand how this stance is deeply tied to the ways she has seen herself as a helper both in other areas of her life, such as with family, as well as since early on in her medical training. Recalling a difficult time when she developed acute anxiety as result of working in an abortion clinic and the counseling staff prevented her from speaking to the patients, she said:

**Donna:** My voice was taken away.

I was put in a clinic and I didn’t have a voice.

It was horrible ((*laughs*)).

Like, to this day I can remember how horrible it was.

And really, when you think about it, what’s the big deal?

You’re going in and doing an abortion anyway, what is the big deal?

For me it was a very big deal to **not have a voice and to not connect to the patient.**

Donna sees her voice as an instrument that allows her to build bridges between herself and other persons, and thus an invaluable tool for providing help to those she is in a position to care for. We have seen a continuity between personal and professional spheres in the value that Donna places on her ability to see incisively what is at issue in a given situation and the strong voice that she has used to remedy what she sees as being wrong. This model of connecting with, coming to know, and “be there for” others has both personal resonance, intersubjective value

from hers and others' perspectives, and sociocultural currency, and it deeply informs the practical forms of clinical care she gives for vulvar pain.

Several more passages from the interviews with Helen underscore how a different personal orientation, both in how she experiences being herself and how she understands what it means to interface with the world of others, is traceable from her childhood memories through to her role as a vulvodynia specialist. She recounts that:

**Helen:** (.) Um, when I was a young teenager,  
when I was like twelve or thirteen, and **a really pretty awkward kid—**

**Cari:** *((laughing))* As we all are at twelve or thirteen.

**Helen:** Yeah. Yeah.

And, some people look at it and others don't.

And I remember thinking,

"I'm never gonna forget what this feels like.

So that **I can always help people who do feel that way.**"

I remember that.

From an early age, a recognition of both the felt isolation and of her own affective experience and the knowledge that it was a human experience broader than hers alone attracted her to a cultural model of care as making a commitment to provide help to those who feel isolated, marginalized, or just "really pretty awkward". Below, she recounts how this mentality carried through to her decision to pursue OBGYN:

**Cari:** Well, if you'd wanna talk more about how you did end up choosing gynecology as a specialty (...)?

**Helen:** Um, so remember, it was a boys' club, and—(...)

So what generally happened was, **the man told you what you were gonna do, and then you did it.**

**Um, and I had a lot of problems with that.**

And, the biggest problem was when I was in my third year (.)

Um, and, we were, in— in his [her clinical preceptor’s]— a— in an office,  
and he had, examined I guess, this woman who’d come in with her boyfriend.  
And, her boyfriend had wanted to know (.) if there was something wrong with her.  
Because, whenever they had sex, she could (.) expel air from her vagina.  
And so he was concerned there might be a hole (.) between her rectum and her vagina. (.)  
And, you would think that, I mean— that would be really easy.  
Because the professor— he could say,  
“Well, you’ve got nothing to worry about, she’s completely normal, this is a common thing,  
because of the muscles that surround the vagina,” blah blah blah.  
But what did he say? He said, “You could make a lot of money with this girl.  
Did you know that in Thailand, they have women perform on stage who can do this,  
pretending to smoke a cigarette with their vagina?  
This is a great— great angle for you to explore.”  
And, much like you, [I stood there with my eyes like saucers and went, “Oh dear.”

**Cari:** [Shocking! (...)]

**Helen:** “**Somebody has to, somebody has to go into this who isn’t an animal.**

This is just, unacceptable.”

So yeah, th— I guess **I got radicalized by that experience.**

While Helen’s explanation, above, for choosing OBGYN mirrors Donna’s in that it also turns on issues of misogyny, it adheres closely to stories she told about earlier periods in her life, and diverges from Donna’s reasoning, in that she frames the misogyny of the era primarily as problematic for others, in ways that she saw herself as able to remedy. While “the man” above had no insight into the appropriate way to care for his patient, Helen cast herself as “somebody [who] has to go into this.” Ultimately, based in this kind of worldview, Helen’s involvement in vulvodynia treatment expanded far beyond the limits of her own practice, and she remains an advocate for the cause even after retirement. As part of her lifelong mindset in which

she has been actively dedicated to acting in the interest of others – both those in her immediate spheres as well as much broader and more distant groups of others (as described above, e.g. “we wanted to have a country that was more representative of what the country was”; see also Noddings’ (2013[1984]) and Slote’s (2007) distinction between those immediately present as the “cared-for” and those out of sight as the “cared-about”), Helen often gave grand rounds on vulvodynia to increase awareness of it in the medical community so that more women could have the chance to receive appropriate treatment. The passage below highlights how this kind of broader commitment to other people more generally is made concrete in her involvement with treating vulvodynia:

**Cari:** I remember on the phone when you had first called me you said that this was kind of a—  
a personal crusade for you (.)

what are some of the ways you think that your attitude about it has been like, like a crusade (...)?

**Helen:** I’ve given grand rounds on it, um, not only at [major hospital], but also at other hospitals,  
to try and teach other people—other doctors—to at least recognize what’s probably sitting in front of them.  
Um, so that at least **that person** could manage to save, oh, I don’t know,  
probably three or four or five months, um, of completely worthless whatever. (...)  
Uh, so, I- I think that- at least to raise the consciousness of it, people will say, “okay, maybe this is that.”  
So that, the people would get to somebody on the- on the NVA [National Vulvodynia Association], uh, site.  
Then, then that was a good thing.  
How many **others** I could help, or, could funnel into pain programs that did other interesting things  
that hopefully would advance the research so that more things could get done.  
I mean, I just didn’t want **people** to be stuck sitting there going,  
“Okay, well I guess I’ll kill myself now.”

The overarching divergences I have discussed in the way that Helen and Donna frame the personal and clinical stories they tell, wherein Donna portrays her major projects as being

grounded in responding to attacks on herself from others and Helen describes her aims as being developed out of attempts to understand and improve others' opportunities, may underlie the difference between Donna's use of a projective empathic style, or imagining how she would feel in the other's place, and Helen's use of a receptive empathic style based in listening, as they build disparate epistemologies to understand vulvodynia in the clinic.<sup>5</sup>

As illustrated by the passages above, both Helen and Donna create a sense of coherence and inevitability that link their treatment philosophies with their life narratives via the interview process. Through the use of narrative devices such as backshadowing, they come to see their trajectories, identities, and roles as making sense in a cohesive way, such that these dimensions of self in turn provide a ground for understanding and dealing with challenges they encounter in the clinic and elsewhere. “‘Backshadowing,’ according to Bernstein, ‘is a kind of retroactive foreshadowing in which the shared knowledge of the outcome of a series of events by narrator and listener is used to judge the participant in those events as though they too should have known what was to come’” (Ochs and Capps 2001:5). Helen summarizes this elegantly:

**Cari:** Okay. So, um, given that again, this is just kind of an open-ended life history interview, is there anywhere you wanna start that you feel maybe you wanna follow up on, or, feels important for you to talk more about?

**Helen:** Um, as I was thinking back on it, first I thought, ‘Oh god, how can she listen to all this, this is so beside the point.’

---

<sup>5</sup> Noddings' (2013[1984]) theoretical framework, with its discussion of the role of the carer in what she calls “a relational approach to ethics” is useful for thinking through issues of empathy from the carer/physician's perspective. Noddings argues that, “To confirm another, we must know and understand that other's reality” (2013[1984]:xix). This position leaves much to be debated in terms of what it means to understand another, however, and leaves the door open to different means by which that understanding might come about. Noddings claims that ideally, “The notion of ‘feeling with’ that I have outlined does not involve projection but reception. I have called it ‘engrossment.’ I do not ‘put myself in the other's shoes,’ so to speak, by analyzing his reality as objective data and then asking, ‘How would I feel in such a situation?’ On the contrary, I...receive the other into myself, and I see and feel with the other” (2013[1984]:30). These notions of “projective” and “receptive” empathy are helpful in understanding the relational differences that undergird Helen's and Donna's orientations to care.

And, I think the only thing that might be (.) worthwhile, as a thread, is that you (.) clearly I'm a kid, you know I'm very rooted in the time that I was born in, coming of age stuff, and whatever.

So you're gonna hear the same thematic thing throughout this.

**Like, why I decided to do gynecology, and how I got interested in vulvodynia, all of that is gonna be- you'll go, "Oh. Okay, I could have predicted this. From the high school stuff."**

And, you know, thinking back on it I went, what a moron I was to imagine that it wasn't all, sort of, like, set.

Taking all of the above data into account, we can see, then, that both Helen and Donna frame their relational styles as having been formed through accreted successes in lifelong experiments with and commitments to advocacy, particularly for women. Both of them relate stories in which they have helped others a great deal – including the fact that both of them have been successful in reducing their vulvodynia patients' pain, as evidenced by their increasing number of peer referrals – yet they foreground and acknowledge disparate, yet equally present and valid, sets of human needs, reflecting and reinforcing different ways of undergoing healing through cultivating different ideas about what “really matters”.

***Understanding patients as persons: Potential effects of physicians' notions of competent care***

Disparate understandings of competent care held by individual physicians are undergirded by and give rise to differing beliefs about personhood, agency, and selfhood. Gaines writes that, “Patients, and people in general, are seen and perceived in meaningful terms according to a remembered past and an assumed conception of self (and, hence, of Other)” (1985:234). It is likely already apparent that differences exist between Helen and Donna in this regard. Physicians' approaches to treatment and care contain views of what will make their

patients “better” that are based in and reify ideas of what healthy persons are and do (see Buchbinder 2011, Buchbinder n.d.). By examining how Helen’s and Donna’s treatment philosophies encourage different ways of understanding relating to self and others, we can gain a preliminary sense of some potential effects of the fact that individual carers adopt *particular* culturally-available models of personhood and care.

In the following three excerpts, it is apparent that for both Helen and Donna, exercising agency and control is a key characteristic of personhood that must be cultivated and strengthened in order to heal from vulvodynia.

The fact that Helen has spent much of her life advocating so that others could gain increased agency and freedom is reflected in her stance in the first passage that her role here as well is to make space for her patients to feel they have control within the situation.

**Helen:** [T]he anxiety that a lot of vulvodynia patients have is that **they’ve gotten control of this, and when it gets out of control, they come unglued,**

they freak out because then they have to go *all* the way back, in their brains, to where they were before *anything* worked and believing that nothing would and so they- they just become hysterical!

And I get it. I understand exactly why that would be so.

And, so, you know, you have to, **allow them to understand** that there *will be* bumps in this.

**But that *they* can, make it better.**

For Donna, the failure to resist a lack of agency specifically over one’s own affairs, which she constantly framed herself as combatting and overcoming in her narratives of self, is seen to potentially play a central role in prolonging or even causing the problem to begin with:

**Donna:** I have one patient who (.)

she was the longest pain patient I had whose pain resolved, who stuck with me.

And we worked on it for four years. (...)

Intriguingly, she's pain-free now, since her mother died.

And (.) uh- I don't know exactly what the correlation is.

She loved her mother, her mother didn't (.) umm (.) her mother had dementia,  
and she took care of her mother. (...)

And I think she was trapped. (.) mm and you know

**within six months of her mother's death she was no longer having pain,  
and no longer on pain medicine,  
and her life was back, hers,  
and I just think her mother stole her life.**

Moving beyond this special case to broader understandings of the relationship between personhood and healing from vulvodynia, she acknowledges that, in general:

**Donna: [T]he more you empower the patient, and give them tools to deal with it,  
the more control they feel over the situation,**  
the better they behave and the better their bodies behave.  
So it's sort of amb- a body and mind thing (...).  
You know, there's, some of the treatment can be mindfulness.  
Just being aware of things.  
And **not letting life happen to you.**

Here, we can see a parallel between what Donna sees as a key turning point in treatment to return to a state of healthy personhood – “not letting life happen *to you*” and a core belief about what it means to be a person that has consistently fueled her own experience in the world, traceable throughout her multiple narratives about refusing to let a decision fall into someone else's hands. Her emphasis here on empowering the patient and facilitating an increase in the

“control they feel over the situation” mirrors both a way of being that she values for herself and one which is highly culturally valued.

Picking up an analytic thread from the discussion earlier in the paper on narrative, in the next passage, we can see the deep ambiguity in what it means to Donna to help someone, and how this is tied to a notion of how others must “help themselves”; it seems that the latter is rooted in following her instructions or allowing themselves to receive help from her.

**Donna:** I (.) I’m very (.) sensitive to patients who have pain complications,  
and **I do make a great effort to try to help them.**

But, **when they won’t help themselves, then (.) it’s hard for me.**

**Cari:** Yeah. So what—

**Donna:** And I have some patients, who, no matter what you try to do, they have a reason they can’t do it.

And finally I say to them, **it’s your pain, you can do—  
you know, you can choose how you wanna manage it.**

I can only offer you what I know.

While in the previous passage Donna noted that patients do better when they are empowered and have control, in the second bolded phrase directly above, she implies that the realization of “ownership” of their pain might equally be an unwanted result on their part when she withdraws her care if they don’t cooperate.

Helen spoke about issues of personhood that arose in patients’ tendencies to moralize and stigmatize their own suffering. She recounts dealing with this by working to disconnect notions of illness from those of identity, though the cleavage remains incomplete:

**Helen:** [Y]ou didn’t start seeing people who were less than 30 years of age until a couple years ago.

Then you started to see them. Um,

**Cari:** I wonder what happened!

**Helen:** Well, I- once again, I think that people got- they-  
they rose in consciousness to going, wait a minute, so this *isn't* right.  
It isn't that there's- that I'm a bad person—  
so that they *could* come in.

**Cari:** mmmm. Did you have people tell you that they thought this means they're a bad person?

**Helen:** Yup. Or that they didn't love their fiancé, or blah dee blah dee blah blah.  
And you would think, 'Poor person! Oh my god!'

**Cari:** mmmm. Yeah.

Did you feel like you had a- a way of dealing with that that was kind of counseling-like?  
Or I mean, how would you respond, especially when you have a not-infinitely long visit?

**Helen:** Well, certainly **I would go into the fact that there were a lot of people who have this,  
and I was having a hard time believing that they were all bad people ((laughs))  
and that, frankly, they could be a bad person if they wanted,  
but I don't think it had anything to do with this...**

Helen responds by constructing a narrative (highlighted in bold) which at once constitutes her patient as a member of a group or population of “people who have this”, and at the same time as not defined by this condition or fixed by her recognition of them as persons, because the kind of person each patient is has more to do with what “they wanted” than it has “anything to do with this [vulvodynia]”. The above excerpts illustrate the potential for physicians' disparate notions of competent care to influence how patients come to conceptualize and relate to their pain in various socially-sanctioned or disapproved ways (see also, for example, Throop's (2010) discussion of discourses on “suffering for” and “mere suffering” among sufferers of pain in Yap).

Care is always sought and given against the backdrop of cultural norms and shared (at least to some extent) imaginaries, and people's quite strong desires and needs to fit into these

social groups always exist in tension with, and at the same time are entangled in the very constitution of, patients' senses of their own unique individuality. In the passage below, Helen demonstrates a keen awareness of this imbrication of, on the one hand, patients' experiences of unique identity, e.g. a "core self...*your* basic definition of who you are" and on the other hand, the drive to fulfill social role expectations, e.g. "women are generally warm, and wanna be with other people...".

**Cari:** So in your kind of philosophy, I guess, about the condition, did you feel like, getting counseling kind of was an essential part of healing?  
Or did you feel like that could help—

**Helen:** Oh yeah. Oh yeah.

Now, you may wonder— uh— I think that frankly not being able to have sex, and knowing that, which often prohibits you from feeling physically close to a man any other way, um, is a narcissistic injury.

You know what I mean by that, yeah?

**Cari:** No, I— yeah, I'd love to hear—

**Helen:** A narcissistic injury is an injury to the *core self*.

Uh, impotence. Infertility.

A-anything that negates what you think is the basic definition-

***your basic definition (.) of who you are.***

***You're a woman.***

***Women generally are warm, and wanna be with other people,***

who they can be with, whether they're women- other women, or whether they're men.

They want to be *able* to produce a child.

Even if they choose not to have one.

They want to be *able* to.

They don't want to be said— told— 'You're defective!' which is how they think of themselves.

'Oh my god, I'm defective.'

So, I— I don't even think that you need to, uh, postulate four months of people saying,

'Uh I don't know what you have,'

to— to un— you know, to have those feelings of,

'Oh my god! **What am I?** If I can't do all this.'

Helen recognizes that vulvodynia, in precluding a key performative act of heteronormative gender (heterosexual sex), deeply disturbs the interface between these two facets of self which are typically felt to be integrated in women's senses of identity (see Butler 2007[1990]). She is highly reflexive about the fact, then, that part of her job as a healer is to guide women back to a place where the socially performed dimension of self can be made accessible once again and hence be re-integrated with what is imagined to be a thusly 'healed' core self (see Kaler 2006). Significantly, this knowledge does not involve imposing artificial or reductionist treatment goals onto patients from the outside; Helen's treatment approach, based from the outset in listening to the patients' perspective, appears to be one that elicits this as a goal from patients themselves, though of course this claim requires more data from the patient's perspective.

Below, Donna elaborates on how she helps patients through employing "[her] philosophy that it's a neuropathy, and treat it like it's a neuropathy, and explain it to patients like a neuropathy," explaining that:

**Donna:** A neuropathy is a (.) painful nerve message (.) long after (.) the nerve stimulus is gone....

And if you can block that,

then you can stop the pain.

**So first it's reassuring to patients to hear** it's not from a big mass, a cancer, an undiagnosed hideous infection, it's not flesh-eating bacteria.

**There's ten thousand things it's not.**

**It's an errant nerve.**

**Cari:** Do you think that's pretty much always what it is,  
if it is [vulvodynia and not some other condition? (...)]

**Donna:** [Yeah, if it looks normal.

Yes, **that's what it is,**

**it's a nerve**

**it's a nerve,**

**it's a nerve,**

**it's a bad nerve** (*(sing-song voice)*)

Significantly, the “ten thousand things it's not” also includes her commitment to an understanding that it's not “nothing,” “fine,” or “all in your head,” as Donna herself had been told before about the source of her own hip pain. She recounted:

**Donna:** Two years ago, I developed osteoarthritis of my hip from an injury (...)

And, I wound up having a hip replacement two years ago, that went fine,  
but had a major complication a month later, I had a dislocation- the joint dislocated,  
and has never been okay since.

And, I have pain since then, which is very disappointing,

'cause I can't walk more than a mile- I like to walk. (...)

And the doctor that I went to was ridiculous. (...)

He said, “There's nothing wrong with you, you're fine.”

I said, “I'm not fine, I can't walk (.) without pain.”

You know, so, **I didn't really appreciate his attitude of “you're fine”.**

**It's a r- major flaw (.) in dealing with m- a human. (...)**

I think it's okay to say “**Your xray is fine**, let me refer you to someone else who can help you with this.”

But to tell me, “**You're fine.**” (.) It's ridiculous.

I'm pretty angry with him.

Donna experienced this physician's feedback as highly problematic both because it denied any 'legitimate' pathophysiological etiology for her pain and because it conflated her x-ray being fine with herself as a person being fine, when in fact a facet of her personhood – her ability and desire to walk – had been disrupted and broken. She thus uses a standard diagnosis as a way to confirm the validity of her patients' felt senses of damaged personhood.

In the data above, we can start to see how differences in physicians' understandings of competent care, based in their own experiences and values, can have potentially significant and very different effects for their patients' experiences of healing. In this way, we might open ourselves to exploring how dialogue from clinical interactions reflects transactions between the physician's lifeworld and the patient's lifeworld, shaped importantly by and within structural and institutional realities.

### **Concluding comments**

I have sketched out, above, how examining physicians' understandings of what it means to provide competent care for their patients might allow us to trace how professional expertise in explaining and solving problems is rooted in practitioners' uniquely patterned ways of being in the world. In Hahn and Gaines' foundational volume, *Physicians of Western Medicine*, Thomas Maretzki outlined three ways that anthropologists can study physicians: (1) as part of a professional organization or institution, (2) as a clinician in interaction with patients, or, (3) "as a human being, thrust into a role demanding unusual adaptation...The issue of the physician as social being...is an essential factor in understanding the physician's call to the profession, and the molding by each physician of the core element of practice, the doctor-patient relationship" (1985:32) This paper represents an attempt to pick up the analytical thread from this third type of

proposed project, which at the time it was written and seemingly through today, remains the least studied of the three avenues.

I have gestured here toward how an investigation of the ways that different styles of expertise are developed out of physicians' unique life narratives might add to current conversations about competence and care. Locally salient ideals of competent care are always produced and continually contested within relationships, in which health care providers are pivotal actors; understanding how individual clinicians vary in interpreting what is "really" at stake in healing from a given condition might make more visible the ways in which multiple, complex discourses on illness, treatment, and health are continually being constructed and circulated.

Physicians' own understandings of competent care always and only reach patients through enactment in the intersubjective medium of the clinical encounter. The ways that these philosophies are taken up by patients, and the relational and sensory modes by which they are delivered, remain important areas for future research. Clinical ethnography in this area would benefit from tracking the ways in which individual notions of clinical competence are communicated through multisensory channels as well as potentially different forms of empathy (e.g. Noddings' analytic frame of 'projective' vs 'receptive' modes of empathic relating). Throop (2012) has shown how touch, in particular, may be an important locus for understanding empathy and care in the treatment of pain.

Questions about the construction of biomedical expertise also tie closely to debates about physician authority and power, which deserve more attention in future work on individual clinicians. Much writing on the doctor-patient relationship within poststructuralist and critical paradigms, such as Foucault's (1994[1973]) theorization of the "medical gaze," Waitzkin's

(1983) Marxist analysis of medical ideology as a form of social control, and Mishler's (1984) description of "normative" medical practice as distancing, has produced compelling arguments for seeing medical authority and power as pervasive, dominant, and oppressive forces in the clinical relationship. Even so, Byron Good (1994) warns against universalizing this way of thinking, given that despite its dark potentialities, "Medicine is not all war or exploitation....It is also a conversation, a dance, a search for significance" (Good 1994:60). Though by no means intending to dismiss questions of power and inequality in the clinic, this paper has placed its focus more firmly within the latter perspective.

Mary-Jo Good has called for more complex understandings of 'professional dominance', pointing out that technological advances and structural changes in the practice of medicine, as well as increasing access to popular health knowledge and increasing numbers of lawsuits by patients, have disrupted basic presumptions of physician competence, unsettling perceptions of physicians' uncontested power in the public imagination (1985:248). The two physicians' descriptions of their treatment strategies given here might provide examples in such a discussion, such as Helen's active use of listening to sort patients into narrowly defined diagnostic categories, and Donna's complex implications about the "ownership" of pain, as well as her use of her voice to validate patients' experiences without listening, which problematize any simple assumed relationships between expertise, power, and dis/empowering patient others.

Finally, it would be useful to explore more thoroughly how, in the case of vulvar pain in particular, the historicity of physicians' embodied gendered experiences, as part of larger socio-historical trends, are particularly important cultural and personal resources that come to bear on their treatment philosophies concerning a "women's issue" whose treatment is deeply tied to socially-embedded notions of how to define and achieve sexual health. It would be particularly

worthwhile to trace how physicians and patients engage in similar and different ways with broad social and cultural discourses about how gender “matters” for being in the world, as well as examining similarities and divergences in their theories about the relationship between vulvar pain and ‘womanhood’. Future fieldwork in the clinic would thus productively explore how women’s and physicians’ goals for healing are both shaped in broad social contexts, examining how notions of sexual health emerge from and may well contribute back to widely circulating discourses about gender and sexuality. Han (2012) models a nuanced approach to thinking about how people relate to such broad cultural categories as gender in lived experience, as she attends to how notions of the normative are reflected and refracted within actual lives, showing how individuals relate to cultural expectations in unique, fragmentary, experimental ways. In observing how clinicians’ philosophies shape physician-patient interactions in real time, it might be productive to ask, how do physicians and patients both fuel and react to the process of homogenization that results from framing each other as members of groups such as “women”? To what extent and how might acknowledging membership in such groups facilitate appropriate care, and conversely, how might such acts of grouping actually hinder effective care?

For the moment, the goal has been to lay a conceptual foundation for exploring how attending to clinicians’ lifeworlds might help us reach a fuller of understanding of how expertise is shaped in important ways by clinicians’ life experiences, orientations, and values, and thus how competent care may be envisioned and pursued in multiple meaningful ways in the clinical context. Further research is necessary to explore how these concepts might productively illuminate analyses of clinical interactions, as well as to shed light on how physicians’ different conceptions and enactments of expert care affect how patients experience illness and healing.

## Appendix: Transcription Guide

(( <i>abc</i> ))	Description of nonverbal interaction
—	Self-interruption
::	Extended phoneme
(.)	Short pause
{...}	Long pause
(...)	Omitted text
[	Overlapping speech
[abc]	Clarifying or disguising referent
( )	Unintelligible speech
<i>Italic</i>	Emphasized word or syllable
<b>Bold</b>	Item of analytic focus

Please note that for increased readability, the majority of backchanneling by the interviewer during informants' speech has been omitted (e.g. "mhhh", "okay", "yeah")

## References

- Baszanger, I. (1998). *Inventing Pain Medicine: From the Laboratory to the Clinic*. New Brunswick, NJ: Rutgers University Press.
- Bruner, J. (2003). *Making Stories: Law, Literature, Life*. Cambridge, MA: Harvard University Press.
- Buchbinder, M. (in press). *All in Your Head: Making Sense of Pediatric Pain*. Los Angeles: University of California Press.
- Buchbinder, M. (2011). Personhood Diagnostics: Personal Attributes and Clinical Explanations of Pain. *Medical Anthropology Quarterly* 25: 457–478.
- Butler (2007[1990]). *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.
- Carr, E.S. (2010). Enactments of Expertise. *Annual Review of Anthropology* 39:17-32.
- Charon, R. (2006). *Narrative Medicine: Honoring the Stories of Illness*. New York: Oxford University Press.
- D'Andrade, R. (1984). Cultural Meaning Systems. In R. A. Schweder and R. LeVine (Eds.), *Culture Theory: Essays on Mind, Self, and Emotion* (pp. 88-119). Cambridge: Cambridge University Press.
- Foucault, M. (1994[1973]). *The Birth of the Clinic: An Archaeology of Medical Perception*. (A. M. Sheridan Smith, Trans.) New York: Random House.
- Gammeltoft, T. (2014). *Haunting Images: A Cultural Account of Selective Reproduction in Vietnam*. Los Angeles: University of California Press.
- Garro, L. (1994). Narrative Representations of Chronic Illness Experience: Cultural Models of Illness, Mind, and Body in Stories Concerning the Temporomandibular Joint (TMJ). *Social Science & Medicine* 38(6):775–788.
- Garro, L. (2000). Cultural Knowledge as Resource in Illness Narratives: Remembering through Accounts of Illness. In C. Mattingly and L.C. Garro (Eds.), *Narrative and the Cultural Construction of Illness and Healing* (pp. 70-87). Los Angeles: University of California Press.
- Garro, L. (2001). The Remembered Past in a Culturally Meaningful Life: Remembering as Cultural, Social, and Cognitive Process. In C. Moore and H. Mathews, (Eds.), *The Psychology of Cultural Experience* (pp. 105-147). Cambridge: Cambridge University Press.
- Garro, L. (2007). “Effort after Meaning” in Everyday Life. In C. Casey and R. Edgerton (Eds.), *A Companion to Psychological Anthropology: Modernity and Psychocultural Change* (pp. 48-71). Malden, MA: Blackwell Publishing.

- Good, B. (1994). *Medicine, Rationality, and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.
- Good, M.J. (1985). Discourses on Physician Competence. In R. Hahn and A. Gaines (Eds.), *Physicians of Western Medicine: Anthropological Approaches to Theory and Practice*. (pp. 247-267). Dordrecht, Holland: D. Reidel Publishing Company.
- Good, M.J. (1995). *American Medicine: The Quest for Competence*. Los Angeles: University of California Press.
- Han, C. (2012). *Life in Debt: Times of Care and Violence in Neoliberal Chile*. Los Angeles: University of California Press.
- Hahn, R. (1985). A World of Internal Medicine: Portrait of an Internist. In R. Hahn and A. Gaines (Eds.), *Physicians of Western Medicine: Anthropological Approaches to Theory and Practice*. (pp. 51-111). Dordrecht, Holland: D. Reidel Publishing Company.
- Hahn, R. and Gaines, A. (1985). *Physicians of Western Medicine: Anthropological Approaches to Theory and Practice*. Dordrecht, Holland: D. Reidel Publishing Company.
- Hallowell, A.I. (1955). *Culture and Experience*. Philadelphia: University of Pennsylvania Press.
- Hollan, D. (2012). On the Varieties and Particularities of Cultural Experience. *Ethos* 40:37-53.
- Hollan, D. (2008). Being There: On the Imaginative Aspects of Understanding Others and Being Understood. *Ethos* 36: 475-489.
- Hollan, D., and Throop, C.J. (2008). Whatever Happened to Empathy?: Introduction. *Ethos* 36(4):385-401.
- Holmes, S. (2013). *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States*. Los Angeles: University of California Press.
- Holmes, S., Jenks, A., and Stonington, S. (2011). Clinical Subjectivation: Anthropologies of Contemporary Biomedical Training. *Culture, Medicine and Psychiatry* 35:105-112.
- Kaler, A. (2006). Unreal Women: Sex, Gender, Identity and the Lived Experience of Vulvar Pain. *Feminist Review* 82: 50-75.
- Kempner, J. (2014). *Not Tonight: Migraine and the Politics of Gender and Health*. Chicago: University of Chicago Press.
- Kleinman, A. (1980). *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*. Los Angeles: University of California Press.

- Kleinman, A. (2006). *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*. Oxford: Oxford University Press.
- Leavitt, S. (2007). Positioned Meaning in Personal Narrative. In J. Wassmann and K. Stockhaus, (Eds.), *Experiencing New Worlds* (pp 78-94). New York: Berghahn Books.
- Levy, R., and Hollan, D. (1998). Person-Centered Interviewing and Observation in Anthropology. In H. Russell Bernard (Ed.) *Handbook of Research Methods in Anthropology*. (pp. 333-364). Walnut Creek, CA: Altamira Press.
- Lock, M. (1985). Models and Practice in Medicine: Menopause as Syndrome or Life Transition? In R. Hahn and A. Gaines (Eds.), *Physicians of Western Medicine: Anthropological Approaches to Theory and Practice*. (pp. 115-139). Dordrecht, Holland: D. Reidel Publishing Company.
- Maretski, T. (1985). Including the Physician in Healer-Centered Research: Retrospect and Prospect. In R. Hahn and A. Gaines (Eds.), *Physicians of Western Medicine: Anthropological Approaches to Theory and Practice*. (pp. 23-47). Dordrecht, Holland: D. Reidel Publishing Company.
- Mattingly, C. and Garro, L. (2000). *Narrative and the Cultural Construction of Illness and Healing*. Los Angeles: University of California Press.
- Mattingly, C. (1998). *Healing Dramas and Clinical Plots: The Narrative Structure of Experience*. Cambridge: Cambridge University Press.
- Mishler, E. (1984). *The Discourse of Medicine: Dialectics of Medical Interviews*. Norwood, NJ: Ablex Publishing Corporation.
- Mol, A. (2002). *The Body Multiple: Ontology in Medical Practice*. Durham: Duke University Press.
- Nakamura, K. (2013). *A Disability of the Soul: An Ethnography of Schizophrenia and Mental Illness in Contemporary Japan*. Ithaca: Cornell University Press.
- Noddings, N. (2013 [1984]). *Caring: A Relational Approach to Ethics and Moral Education*. Los Angeles: University of California Press.
- Ochs, E. and Capps, L. (2001). *Living Narrative: Creating Lives in Everyday Storytelling*. Cambridge, MA: Harvard University Press.
- Ricoeur, P. (1981). Narrative Time. In W.J.T. Mitchell (Ed.), *On Narrative* (pp.165-186). Chicago: University of Chicago Press.

- Schutz, A. (1967 [1932]). *The Phenomenology of the Social World*. (G. Walsh, Trans.). Chicago: Northwestern University Press.
- Slote, M. (2007). *The Ethics of Care and Empathy*. New York: Routledge.
- Strauss, C. (2005). Analyzing Discourse for Cultural Complexity. In N. Quinn (Ed.), *Finding Culture in Talk: A Collection of Methods*. (pp. 203-242). New York: Palgrave.
- Taylor, J. (2003). Confronting “Culture” in Medicine’s “Culture of No Culture.” *Academic Medicine* 78(6):555-559.
- Throop, C. J. (2008). On the Problem of Empathy: The Case of Yap, Federated States of Micronesia. *Ethos* 36: 402–426.
- Throop, C. J. (2010). *Suffering and Sentiment: Exploring the Vicissitudes of Experience and Pain in Yap*. Los Angeles: University of California Press.
- Throop, C. J. (2012). On the Varieties of Empathic Experience: Tactility, Mental Opacity, and Pain in Yap. *Medical Anthropology Quarterly* 26: 408–430.
- Timmermans, S., and Berg, M. (2003). *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care*. Philadelphia: Temple University Press.
- Waitzkin, H. (1983). *The Second Sickness: Contradictions of Capitalist Health Care*. Lanham, MD: Rowman & Littlefield Publishers.