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Fadiman, Anne. 1997. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. New York: Macmillan.

James Naas

Anne Fadiman's ethnography *The Spirit Catches You and You Fall Down* explores and documents how cultural barriers between the Hmong parents of Lia Lee and western medical practitioners led to the vegetative state of Lia Lee, because a successful treatment plan never came to fruition.

The Lee family belongs to the Hmong ethnic group, which consists of hill tribes that practice swidden agriculture in the highlands of Laos, Vietnam, and China. The Lees migrated to the United States from Laos at the end of the American war in Vietnam. The geographic context of this book is thus very complex as a result of historical differences and events that played a role in how the Lee family and the doctors struggled to cure Lia's epilepsy. In Anne Fadiman's perspective, "the Hmong are so preoccupied with medical issues because they are so concerned with their wellbeing in life and in the afterlife" (Fadiman 2012, 61). The Hmong are mainly concerned about keeping their soul from wandering and not getting sick, but once they pass away their souls must return home by retracing their steps from the very beginning, and this is where one of the Lees most dire problems arises. "The Lees believe that the souls of most of their family members have a long way to travel, since they will have to retrace their steps from Merced, California...to Portland Oregon; to Honolulu, Hawaii; to two Thai refugee camps; and finally back to their home village in Laos" (Fadiman 2012, 6).

The geographic and social context of the account are intertwined in that the geographic background of the Hmong is much bigger than the events that take place in Merced; but of course this geography adds to how the situation unravels at the Merced Community Medical Center (MCMC). Traditionally the Hmong do not practice western medicine nor had they encountered it until they arrived at the Thai refugee camps, and became more exposed to its practice in the United States. The Hmong practice spiritual healing and shamanistic rituals, also known as *neeb*. These rituals enlist various tools such as sacred animals to please *dabs* (bad spirits), and musical tools like gongs and finger bells, blessed water, chants and herbs, as well as other traditional healing methods to find a person's lost soul. Biomedicine in the U.S. obviously does not practice these activities, and this is where the healing systems of the western doctors and Hmong came into conflict.

The Hmong who live in Merced do not completely embrace western medicine because to them it is very invasive and can cause them to lose their souls. Anne Fadiman notes that such biomedical practices as anesthesia, surgery, autopsies, and repeated blood samples can cause the soul to wander, as well as various illnesses, death, and the possibility that the person will be physically incomplete, once they are reincarnated, because the body is essentially being tampered with (Fadiman 2012, 33). This is why the Lees and other Hmong clans find it so troublesome to go to the hospital and refuse to comply with the doctors' methods. In return, doctors at the MCMC became frustrated and exhausted when dealing with the Hmong while trying to save their lives. The whole situation is worsened; neither side was able to break through cultural barriers and understand the opposite side even though they both came in with good intentions.

As a result, Anne Fadiman argued that Lia's fate was brought upon not by septic shock or noncompliant parents or medicine, but by cultural misunderstanding (Fadiman 2012, 63). While working with Foua and Nao Kao (Lia's parents) and the medical practitioners at the MCMC, the author comes up with a number of recommendations that may help to avoid and bridge a cultural gap between existing biomedical practices in the U.S. and Hmong patients' beliefs and practices and to help other patients of different ethnicities and beliefs.

Fadiman's first recommendation is medical pluralism. She states that the Hmong do not think the doctors are completely ignorant or misguided in any sense; it's just that western medicine does not hold all the answers to illness and healing. For example, Nao Kao gave his perception of things, "The doctors can fix some sicknesses that involve the body and blood, but for us Hmong, some people get sick because of their soul, so they need spiritual things. With Lia, it was good to do a little medicine and a little *neeb*, but not too much medicine, because it cuts the *neeb*'s effect" (Fadiman 2012, 100).

Recommending medical pluralism with multiple treatment options, especially culturally specific ones, would have been a better start. This way, Lia's parents would have complied with the medicine the doctors were giving her while giving Lia traditional Hmong remedies.

Restructuring the clinical gaze – where the doctor only treats the disease and not the person and their concerns (Foucault 1973) – is another solution Anne Fadiman poses. "Instead of looking at what diseases the patient has, look at what person the disease has." Bringing back the "whole doctor-whole patient model... the doctor comes with his or her full humanity... and the patient is viewed as a complete person" (Fadiman 2012, 275).

This relationship can help doctors “see through” the idea of curing the disease to understand the context of how the disease started and the proper way to treat the person, so that the disease or problem can be solved (Wendland 2010). This means that cultural relativism – which views each culture as unique, equal, and valuable – can lead to a breakthrough in understanding differences in cultural medicine. This is especially true in Lia’s case: her parents and doctors viewed her seizures differently, which led to inconsistencies in how each side tried to resolve or control her epilepsy.

An overarching solution came when Fadiman was working with Arthur Kleinman, a psychiatrist and medical anthropologist. He came up with a list of suggestions for doctors when dealing with patients who do not see eye to eye. Fadiman summarizes these suggestions as mediation and realizing the power that culture plays when it comes to both the US biomedicine and that of the patient (Fadiman 2012, 261). Kleinman suggests in the case of the Hmong, finding a respected community member or cultural broker to mediate and negotiate means of treatment in order to reach a compromise. Then, it is important for a doctor to see that biomedicine has its own intentions of saving a patient through standard procedures and beliefs. Understanding those terms will shed light on the culture of the patient, which has its own intentions, beliefs and rules as well. Breaking down ethnocentrism – the belief that your culture or point of view is superior to others, to find agreements is another main goal in order to have a successful prognosis and healing.

In identifying how this ethnography is similar to other texts I would like to look at the social roles and perceptions people take on throughout the book. First, I will compare

how actors are stereotypically viewed and perceived in a society that they are foreign to. Second, I will explore how they handle and embrace new forms of liminality in society.

*The Spirit Catches You and You Fall Down* bears many similarities to Seth Holmes' ethnography, *Fresh Fruit, Broken Bodies*. One is the topic of stereotypes and acculturation that Fadiman and Holmes add to medical anthropology discourse (as well as broader discussions in anthropology and globalization). Holmes interviews J.R., a retired mechanic who has lived in the American west and tries to get his view of Oaxacans and other "foreigners." J.R.'s deprecating assumption is that "Mexicans" get free welfare and are lazy. At the same time they are a threat because "they take farm worker's jobs" (Holmes 2013, 159). When it comes to the topic of acculturation and why foreign workers and citizens face great difficulties, J.R. and others view it as a one-sided relationship and assigns the blame solely to immigrants. "That's why the Mexicans are having problems and now your Hmong's are having problems is that they don't want to change. They want to keep their culture" (Holmes 2013, 160). This statement indicates that they simply don't belong here and are a burden on the system; they resist acculturation. Thankfully, Holmes dispels that notion with examples of hardworking Oaxacans who do what they can despite facing great odds.

Fadiman also relates this stereotype when interviewing Foua, Lia's mother. Fadiman notes that Foua, loves America, "You are comfortable. You have something to eat. But you don't speak the language. You depend on other people for welfare" (Fadiman 2012, 105). The loss of self-identity hurts the most. Yet, Foua dispels J.R.'s assumption about the Hmong: they love the United States they do wish to work hard, yet the American government took it upon themselves to provide for the Hmong due to the

war. Joua, another informant for Fadiman, also dispels the stereotypes about refugees that existed in the 1980's and 90's. "I will work if I can... but probably I cannot... I don't think I will learn one word of English. If my children put a heart to it, they will be able to learn English and get really smart. But as for myself, I have no hope" (Fadiman 2012, 209). Here, Joua, who is not lazy by any means, escaping from Laos and experiencing a life as a refugee, now faces another new challenge by living in America. He admits that it is difficult and has partially given up, but he has given everything he can to his children in order for them to succeed in America, just like Foua and Nao Koa's other children have succeeded.

The second part of social roles and perceptions that Fadiman discusses is the view of vegetative patients as liminal beings. Fadiman contributes to the ongoing discussion in medical anthropology about vegetative patients by documenting the views of Lia's caretakers. Now, one way to view comatose and vegetative states is in the sense of liminality; of being "neither alive, dead, nor self-regulating" (Kaufman 2000, 79). Sharon Kaufman's ethnographic research with vegetative patients revealed that it was up to family members to ultimately decide whether or not these patients were alive. Such decisions were based on love, memory, and respecting personal requests. Interestingly enough, even though Lia remained alive for quite some time after the removal of life assisting devices, her doctors referred to Lia in the past tense in the aftermath of her grand mal seizure. Fadiman argues that this was, "mainly because medicine had once made extravagant claims on her behalf that now had been renounced" (Fadiman 2012, 257).

Lia's parents, on the other hand, fed her, bathed her, and performed sacrificial healings for her. She was indeed alive to them; it was just that her soul had left her body. This view shows a clear distinction yet an intertwined relationship between soul and body. In their eyes, the decision to keep Lia alive was because her future was uncertain. To them there was hope to find her soul again and love certainly played a role in that hope. Kaufman later notes that the decision by families to keep people alive through technology (or in Lia's case through constant care by her parents) rests on the idea that improvements will be made to better a person's quality of life in the hopes that one day liminality can enter a new stage.

In addition to describing the social roles and perceptions that influence health and healing, Anne Fadiman also contributes to many other topics in medical anthropology. These include the neo-liberal policy of American hospitals, cultural competency, medical pluralism, social contexts of illnesses, and the clinical gaze.

In his ethnographic work about migrant farmworkers from Mexico working in the U.S., Seth Holmes criticizes the structure of the American health care system in that it not only hurts migrant farmworkers, but also Americans. Holmes notes that spending time to fully treat the patient can put practices in jeopardy by not generating enough profits from each visit. As a result, doctors try to diagnose or attempt to treat the patient as quickly as possible, focusing on the disease, not the person (Holmes 2013, 125). Anne Fadiman uncovers the (same?) problem through one of her informants, who says, "The doctor is very busy...if he does not produce, his economic will be deficit. But the Hmong, he will want a doctor to calmly explain to him and comfort him. That does not happen. I do not blame the doctor. It is the American system" (Fadiman 2012, 62). The doctors are

pressed for time and try to treat Hmong patients as best they can, but understanding the Hmong's complicated needs takes time that doctors may not have when dealing with many patients.

In some regards I do think Anne Fadiman is actually creating or at least contributing significantly to cultural competence and medical pluralism, as others have cited and praised her studies. Fadiman describes the cultural healing beliefs and traditions of cupping, coining, animal sacrifice and using musical instruments to help shamans and their helpers guide souls back to their bodies (Fadiman 2012, 61). Patricia Leigh Brown, while reporting for the *New York Times*, references Fadiman in her article, explaining that as a result of misunderstandings and miscommunications, doctors made decisions with the Hmong that led to so many terrible outcomes, such as in the case of Lia Lee. Leigh writes that the fallout of the case led to soul-searching and new policies to build trust between doctors and Hmong patients. Now, shamans are able to practice a little *neeb*, minus the animal sacrifices, in hospitals (Brown 2009). In this regard, I think Fadiman illustrates a great case for medical pluralism so that patients have multiple healing options available to them other than biomedicine, in the hopes that treatment will be successful.

Another area that Fadiman contributes to the field of medical anthropology is her discussion of the social contexts of the body and the social histories of the body and illness. One example that Fadiman mentions is the concept of "total body pain." "Since the aftermath of WWII, that because of all the enormous psychological traumas they have suffered, refugees of all nationalities have higher rates of somatization, in which emotional problems express themselves as physical problems" (Fadiman 2012, 69). In

these instances doctors began to realize that the pain was real, but had no idea of what was happening because they could not locate the source of pain.

Understanding the embodiment of trauma as result of migrating for your life against various challenges is just one step in comprehending why a person feels the way they do. While studying organ transplants in Egypt, Sherine Hamdy understood that, "Different parts of the body carry with them different social histories, symbolic meanings, outcomes in transplantations, which influence the ethics of those surgeries" (Hamdy 2012, 17). She discusses the different kinds of ownership that pertain to different body parts like the cornea. Hamdy's main argument is that each body part holds its own, historically determined value. In turn, the unique values surrounding body parts shape understandings of the origin of the illness, and structure the dogmatic beliefs that determine how people respond to illness and ask for assistance. Similarly, the historical and social context of illness is what caused the difficulty that doctors experienced with the Hmong. Nearly every treatment that the doctors suggested for Hmong refugees, such as blood transfusions, medications, incisions and other biomedical procedures, basically intruded upon the sanctity of her souls (in that it could cause the souls to wander). Based on their beliefs and life experiences, the Hmong thus refused medical practices.

Anne Fadiman also contributes greatly to scholarship on the clinical gaze: the viewpoint that seeing the patient not as themselves but mainly as the disease they have, misses the point of treating the person. During the operation to save Lia from septic shock, Dr. Kopacz reduced Lia "from a girl to an analyzable collection of symptoms...thereby able to husband his energies, succeeded in keeping her alive" (Fadiman 2012, 147). He focused on the bodily functions of Lia such as metabolic

acidosis and peripheral perfusion, but failed to recognize Lia as a girl and certainly had no knowledge that that her parents would view the surgery to save her life as life threatening. Seth Holmes (2013) was also a critic of the clinical gaze, as it had reduced his informants, Abelino, Crescencio, and Bernardo from being migrants ailing from structural forces, everyday violence, and political violence, to a worker with a bad knee, an alcoholic wife-beater struggling to cope with authority figures, and an old boxer suffering from an ulcer. Both authors argue that reversing this view that health care practitioners have when dealing with patients is crucial in understanding what the true source of the problem is and finding better solutions to alleviate the problem.

When Fadiman discusses all of these issues in medical anthropology it is not only for anthropology students and ethnographers studying the Hmong, it is also for doctors, nurses, and health care administrators. The book is also written for the Hmong themselves who might find themselves as patients, and for the public who live with them, in the hopes that medical pluralism and other solutions can be achieved.

The evidence Anne Fadiman details and puts forth makes a strong argument for medical pluralism and cultural understanding. Fadiman not only uses Lia's case, but also cases such as cancer, pregnancies and other programs involving vaccinations and testing for tuberculosis, hepatitis, and AIDS. In each example she notes how the doctors and Hmong families were not on the same level of understanding due to language, socio-cultural and caregiving barriers. This made doctor visits into ordeals for the Hmong families, who became afraid of and angry at the health care system. In mentioning health screenings for refugees, "once an applicant is medically excluded by one country of asylum, he is unlikely to be accepted anywhere else" (Fadiman 2012, 67). This was a big

reason why people were afraid of the doctors and encountered the medical system with apprehension. The main problem associated with Lia's case is that perceptions of her condition were not viewed the same way in the eyes of the doctors and Lia's parents. Foua and Nao Koa believed that her seizures were a sign that she could become a *txiv neeb* or a spiritual healer. Jeanine Hilt, a social worker helping Lia's parents, said that they thought "she talked to Gods during her seizures and that they had this euphoric idea that she was a princess" (Fadiman 2012, 114). This view was very different to that of the doctors, who viewed her seizures as increasingly life-threatening.

Fadiman also mentions how by taking Hmong religious beliefs into account, some doctors helped their patients. Fadiman discusses how grants in California were used for, "Integrating mental health delivery services utilizing Hmong healers and western mental health providers" (Fadiman 2012, 269). The grants were deemed a huge success as shamans were enrolled in hospitals to help Hmong patients. As a result, patients were more inclusive of western medical practices if the circumstances were out of the shamans' realm or if the shaman recommended treatment to help assist the problem.

Even though Fadiman brings compelling arguments to bridge the gap between biomedicine and other healing systems, one of her weaknesses seems to be her bias. This bias is evident in her conversation with an epidemiologist who had worked with the Hmong, "I started to lament the insensitivity of Western medicine. She looked at me sharply. "*Western medicine saves lives,*" she said" (Fadiman 2012, 276). Fadiman retraced her steps about how western medicine saved her father from colon cancer, saved her and her husband from infertility, and thought that if Lia had taken her anticonvulsants she could have been saved. But her bias at times lies with the Lees because during her

work she got to know the Hmong community more than she did the doctors; so she had a bigger heart for the Hmong because she got to see them in a different light, not one of noncompliance and not caring, but one of good caretaking people with the best intentions for their loved ones.

Anne Fadiman may not be an anthropologist, but she conducted her research using ethnographic methods such as participant-observation and interviews. Through this work, Fadiman came to understand the power structure and hierarchy of the Hmong with clan leaders at the top. Her ethnographic relationships were arranged by Bliia Yao Moua, a clan leader belonging to the same clan as the Lees. She treated her informants as ‘cultural brokers,’ as Sukey Waller, a psychologist working for the MCMC, instructed her to do. “They teach me. When I don’t know what to do I ask them” (Fadiman 2012, 95). Fadiman admits that she came in with some assumptions about the Hmong. One was that they did not want to be belittled, which she found to be true. So she looked at her status as a woman as beneficial, and found another younger woman to act as her cultural broker so that they would not look like authority figures. Fadiman also knew that she could not be affiliated with the hospital because then she would be mistrusted, so she distanced herself from doctors. Fadiman also treated everyone with respect and built great rapport with the Lees and other Hmong participants. She also participated and observed Hmong traditions such as the marriage ceremony, by dressing up like a Hmong bride to facilitate and secure trust by partaking in Hmong culture.

Even though she was not taught to be an ethnographer, Fadiman does use many skills and methods in the ethnographers’ tool kit. She uses such qualitative methods as participant-observations at sacrificial ceremonies, interviews, written and recorded, all of

them ranging from structured to semi-structured and unstructured. From these interviews she also compiles the life histories of the Lees and many others, showing how their life experiences shaped how they have come to view their world. Fadiman also draws on other works of ethnographers such as Dwight Conquergood, and in newspaper sources regarding stories of the Hmong. Fadiman also samples information from many agencies such as the Senate Judiciary Subcommittee on Refugees and Escapes, the United Nations High Commission on Refugees and other organizations and entities. What makes a great ethnographer is the ability to document meticulously the events of their informants and their stories. Fadiman documents and logs Lia Lee's hospital visits and her prescriptions, she keeps letters from child services, as well as notes from social workers and care providers, all while keeping in mind the emotions and views of Foua and Nao Kao and how they react to these documents. These methods and techniques help to improve the reliability of her findings and validity of her arguments.

Ethnographers see themselves as one of two types. Those that alleviate the suffering and despair of those they work with by getting their stories heard and suggesting solutions derived by their informants. Others see themselves as outsiders documenting human lives while not changing anything at all. Fadiman is an ethnographer trying to change a failed relationship between health care and patients by bringing to light the troubles encountered by Hmong refugees, and by examining what works and why for the Hmong. Philippe Bourgois and Jeffrey Schonberg are similar types of ethnographers who document the lives of drug addicts. Their ethnography includes descriptions of addicts' ability to access health care, health care's view of addicts, what occurred in addicts' lives to contribute to their heroin use, and how addicts fit in the society where

they lived in San Francisco. The main questions driving their research was finding out why people become users, and why America, which is such an economically and technologically advanced country, struggles to treat addicts. Similarly, Fadiman wanted to answer the question of why doctors and Hmong patients had difficulty coming to successful resolutions in seeing treatment regimens through. Though Bourgois and Schonberg had different informants, were trained in medicine, and were conducting research measuring outreach effectiveness for the clinic and health program they were part of, they used the same methods and had the same objectives as Fadiman. In addition they also relied on music, particularly rap to try and explain and draw conclusions about drug consumption practices, and they used photography to analyze the daily lives of their ethnographic informants. Each respective author using his or her own means created well-constructed and moving ethnographies.

The audiences that are most relevant and could gain the most from reading this book are health practitioners, anthropologists, social workers and policy makers. Health practitioners could gain knowledge on how patients of different backgrounds see illness and treatments. The book would help practitioners look at patients differently and understand how patients might view them. Doctors could find the best ways to handle differences in healing systems and find resolutions. Anthropologists and students could use this work in their own studies and use her evidence and methodologies in their fieldwork in medical settings. Social workers are another audience. Learning from the experience of those like Jeanine Hilt could be of use in relaying information back and forth between parties like hospitals, Child Protective Services, and the courts, - and in getting resources that are needed for families that may not know how to get them. Policy

makers could gain from hearing human stories and understanding the reasons for policy failure or achievement. This knowledge could be key for legislation to adopt new programs or classes promoting medical pluralism or cultural competency in the medical field. By understanding where everybody stands in these programs, policy makers have a better chance of assessing and addressing the problems, and of receiving more positive evaluations from the implementation of new programs.

Understanding the history of people would help these professionals as well. For example, the United States promised to take care of the Hmong refugees for their allegiance. They were brought to the States and put on welfare. This policy led to xenophobia and racism from some citizens. If policy makers got the word out to explain why such policies are created, they could alleviate resentment towards people in need. Making laws that can help people practice their spiritual and religious beliefs, like sacrificial ceremonies, is also a good idea, and is based on America's principle of freedom of religion. I think the key point for all of these readers is that if they want to find a solution to a problem then they must listen and understand the concerns of those struggling, particularly in the field of medicine, since people's health is a main priority of life.

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