The delivery of health care can present a minefield of communication problems, particularly in cross-cultural settings where patients and health practitioners come from dissimilar cultures and speak different languages. Responding to the need for in-depth ethnographic studies in cultural and communicative competence, this anthropological account of Maya language use in health care in highland Guatemala explores some of the cultural and linguistic factors that can complicate communication in the practice of medicine. Bringing together the analytical tools of linguistic and medical anthropology, T. S. Harvey offers a rare comparative glimpse into Maya intracultural therapeutic (Maya healer/Maya wellness-seeker) and cross-cultural biomedical (Ladino practitioner/Maya patient) interactions.

In Maya medical encounters, the number of participants, the plurality of their voices, and the cooperative linguistic strategies that they employ to compose illness narratives challenge conventional analytical techniques and call into question some basic assumptions about doctor-patient interactions. Harvey’s innovative approach, combining the “ethnography of polyphony” and its complimentary technique, the “polyphonic score,” reveals the complex interplay of speaking and silence during medical encounters, sociolinguistic patterns that help us avoid clinical complications connected to medical miscommunication.
WELLNESS BEYOND WORDS
WELLNESS
BEYOND WORDS
MAYA COMPOSITIONS OF SPEECH AND SILENCE IN MEDICAL CARE

T. S. Harvey
For Matthew David Heath
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Architects of deconstruction (those who must be cited), tell me, if you know, why when the subjects of anthropology began to speak did you decide that there was nothing more to be said?

Postmodernism need not become what it has, a period that portends the end of the possibility of other questions, the last word of a worn-out slogan, an artifice of intellectual immortality forged by claims of having left nothing unsaid and calls for the deconstruction of not less than everything. What shall we do with the will to speak if the author is dead, when supposedly everything left to say (or worth saying) has already been said? Romain Rolland famously articulated the problem as a “pessimism of the intelligence, which penetrates every illusion” to paralytically ask what one can know, versus the “optimism of the will” (Fisher 2003:88), which can adjourn the councils of despair to ask what more can be done. For the former objects of anthropology seeking full subjectivity, reluctant heirs to “double consciousness,” who like me may have descended from African slaves, Native Americans, and European colonists, this book, an “ethnography of polyphony,” is a prolegomenon to the vitality of voice in anthropology.

Not despite but because of the devastation of deconstruction, voices of lived experience remain relevant to social science; they inform perspectives, affect the kinds of research we do and how we do it, the topics we select and how we present and write about them. My Du Boisian disclosure, not an *apologia pro vita sua*, is included here to articulate the felt tensions between classic anthropological representations of subjects as objects (peoples spoken for by others) and what Roy Wagner (2001) has called “the anthropology of the subject” (peoples speaking for themselves) as authors (inventors) and not merely the objects of someone else’s “re-collection.”
Aware of the relationship of authorship to authority and the innumerable problems of claiming to speak for others (see Spivak 1988; Wantanabe 1995; Pratt 2001; Montejo 2005), the discussions that I present in the book are “opened” but not ended. Comprehensibility is preserved through textual cohesion, but coherence (reader-centered meaning) is left not to the author but to readers and the endless interplay of voices. To this end, I have attempted to resist the conventional urges of authorship that would seem to require conclusions about my more than a decade of research among the K’iche’ Maya of highland Guatemala. Closed-ended conclusions would run the risk of supplanting the vitality of the very same voices that this book seeks to include and engage. Yet anthropological descriptions of voices and experiences, however succinct or eloquent, cannot, as Edie Turner (2005, 2006) would rightly remind us, substitute for the need to have them ourselves. In addition to being a description of the unheard voices of Maya wellness seeking, this ethnography of polyphony is an expression of the will to speak and more important still of a willingness to develop new socio-scientific methods to listen to and understand the voices and discourses of others.

Returning to the reference to Roland Barthes, I might add that if the author is dead, the postmortem will likely reveal that the cause of death was not the endless ascription of unintended significance to the departed word (symbolic violence) but the kind of multivoicedness suggested by Walt Whitman’s observation that “I am large, I contain multitudes.” In proclaiming multiplicity, Whitman suggests that there never was nor could there ever have been a single (monologic) author. Rigoberta Menchú, the Maya Nobel Peace Prize winner who found the veracity and authority of her voice in her autobiography, *I, Rigoberta Menchú* (1996), impugned (see Stoll 1999; Arias 2001), would likely appreciate Whitman’s hyperbolic sentiments. Historically, for Maya peoples, multivoicedness can be traced back to narratives about the dawn of life. Recall that in the Popol Vuh, creation is described as coming forth not from a single voice but from a conversation. To listen in, we consult Dennis Tedlock and Enrique Sam Colop:

K’eje k’ut xax k’o wi ri kaj  
And of course there is the sky,  
K’o wi nay puch Uk’ux Kaj,  
and there is also the Heart of the Sky,  
are’ ub’i’ ri kab’awil. Chucha’xik.  
This is the name of the god, as it is spoken.
In keeping with anthropological concerns for multivoicedness we might well ask whatever became of our excitement with the promise of Bakhtinian polyphony (multivoicedness) or the desire to hear and will to understand “other” voices. Is the logos of our discipline destined to end, to “di-” as it were, in a dialog between “us,” locked in an unending circumambulation? Optimistically, perhaps what is dead is not an author or authorship per se but the mythologie, and on this Barthes might agree, of the author’s monologic singularity and with it the forgery of his or her ultimate authority (see Barthes 1972). With the myth of the single author’s authority silenced (if but partially) or at least restrained (if but theoretically), the voices (logos) of others might be listened for (if not heard) when the hubris of authorship is put aside, leaving coherence to readers and the endless inter- and extratextual play of voices.²

In the current socioscientific environment, to hear, write, and engage multivoicedness in ethnography necessitates attempts to analytically break the cyclical manacles of postmodernist deconstruction. Here, my efforts involve initiating what I term a “heterologue” with “others” whose logos may be so incommensurate with our own as to disrupt our well-defined dialogues and quite possibly our disciplines (see Wantanabe and Fischer 2004).³ Inspired by Bakhtinian notions of heteroglossia, I hope that by cultivating a heterologue the old hegemony of the author’s
monologic voice (and its claims to coherence) that sought to represent “others” will give way to the heterogeneity of polyphony, where multiple presentations of voice and perspective, points and counterpoints, are gathered and entangled without their meanings being mastered or subdued (see Bakhtin 1996, 1999; Evans 2008). After and in honor of Dell Hymes’s work and early contribution to this approach, I have termed this approach the “ethnography of polyphony”; it is a methodological and analytical orientation to the presentation of multivoicedness in ethnography that places the voices of others on more equal footing with authorial ones, a disciplined denial of narrative determinacy (authority) that in ethnography can be detrimental to polyphony and the possibility of heterological engagements.

Contending with heterogeneous voices and perspectives can be, as this book demonstrates, as compelling as it is challenging. Yet a polyphonic stance of inclusion need not lead to self-defeating conclusions that everything is inconclusive, the very antinomy of anthropology that can obstruct the possibility of sharing what we have learned and applying it to human problems and concerns. Indeed, if the original science of humankind, anthropology, is to answer the needs of human beings (however varied) it must ever increasingly do so with and not despite the presence of multiple voices and perspectives.
Borrowing from Robert Frost’s poem “Closed for Good,” much of what I know,

I owe the passers of the past
Because their to and fro
Has cut this road to last,
I owe them more today,
Because they’ve gone away.

The distance between the monolingual inner-city streets of downtown Newport News, Virginia, where I grew up, with its economic disadvantages, educational barriers, and racial inequalities, is a long way from the multilingual Maya world of highland Guatemala where I conducted the research for this book, and further still from the University of California, where I have been afforded the privilege of completing this book. One does not cross such distances or overcome such disparities alone. I would first like to acknowledge by name, those who have passed on, without whom I could not have made this journey: my paternal grandfather, James Harvey Sr., father, James Harvey Jr., maternal grandmother Hazel Young, maternal grandfather Paul Young, and my dear uncle Ronald “Mac” Mitchell, who first sparked in me the desire for education. My greatest privilege, however, comes from the opportunity to thank my mother, Joyce Harvey, and my wife Shagheyegh Sepehri-Harvey. Also, I express my appreciation to Thomas Hart for his friendship and for introducing me to the Nima’ Maya community, my research assistants, Carlos Chacaj and Victoriano Chacaj without whom the research would not have been possible, all of the healers, physicians, nurses, patients, and wellness seekers who graciously participated in the study, the townspeople of Nima’, who opened their homes and extended
friendship to me, and to the Escobar family of Quetzaltenango, who gave me a home away from home.

Professionally, I had the great privilege and am immeasurably thankful to have pursued graduate studies in linguistic anthropology under Eve Danziger at the University of Virginia, who not only taught the field but introduced me to its founders, the late Dell Hymes and his wife Virginia Hymes. Special thanks also to Gertrude Fraser who introduced me to medical anthropology and, more importantly, the power and potential of its application. I am also immensely grateful to George Mentore and Roy Wagner, whose theoretical insights and generous contributions to this work have been both foundational and invaluable. Without their work and early encouragement this book would not have taken its current shape. The book is ultimately a collaborative effort, formed at the nexus of ideas circulating between my mentors, friends, and colleagues, among them (in alphabetical order) Charles Briggs, John Broderick, Atwood Gaines, Douglas Gordon, Richard Handler, Peter Metcalf, Lea Pellett, Charles Ruhl, and Edie Turner.

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INTRODUCTION

My concern with the vitality of indigenous voices (in Guatemala and the United States) began with a recognition of common losses, for me and heirs to legacies of colonialism elsewhere in the Americas, remnants of these voices can be found in our own lives, in the handed-down stories of half-remembered ancestors, African, Native American, and European lives, all clumsily tied and woven together. For some, these voices can be heard in the echoes of native languages still spoken, though sadly many are now too often half understood. What remains of indigenous voices, great and small, oral and written, speak across our disparate histories, cultures, and circumstances not to loss alone but to the endurance, dignity, and worth of human personality. The research presented here and the ethnography of polyphony approach in particular are dedicated to the rediscovery of the vitality of indigenous voices through a commitment to the development of new ways of listening, including describing and analyzing multivoicedness both in the study of interactions and within the composition of ethnography and anthropology.

Ironically, though befitting of globalism and indicative of cultural loss, my first encounter with an indigenous language in my home state was not with one of my ancestor’s Algonquian tongues from that region but instead with K’iche’ Maya, which I heard in migrant labor camps on Virginia’s Eastern Shore. It was there that as an undergraduate I participated in public health projects focused on improving cross-cultural doctor-patient communication. The summer’s sweltering heat in the migrant camps with their overworked inhabitants, deplorable living conditions, and inadequate health facilities seemed eerily reminiscent of historical accounts of colonial times in Virginia; their histories and experiences were interconnected and that fact left an enduring impression on me.
The labor camps, which upended the picture of the inhabitants of Mesoamerica I had inherited from the glossy pages of *National Geographic* as a child, were my introduction to Maya peoples, languages, and cultures and, more importantly, to the communicative and cultural difficulties that they faced in accessing health care in the United States. Initially, I suspected that answers to cross-cultural medical communication problems in migrant labor camps might be found by studying cross-cultural health care interactions in Guatemala but later learned that similar problems (though different in degree and kind) existed there as well. As an undergraduate, this focus on improving doctor-patient communication in U.S. migrant labor camps took me to Mexico and Guatemala for Maya and Spanish language studies and later, as a graduate student, to Guatemala for dissertation and postdoctoral research where I focused on numerous aspects of indigenous health including, cross-cultural medical communication, and health care access. Most recently, I have been researching public health risk translation and communication (see Harvey 2006, 2008, 2011, 2012; Sepehri and Harvey 2009).

The study presented here is based on an initial thirteen months of linguistic and medical anthropological field research (2000–2001) conducted among the K’iche’-speaking Maya of Nima’, a term that means meaning “great or abundant river” that I use as pseudonym for a Guatemalan town of roughly fourteen thousand inhabitants located in the western highlands, and a decade (2001–2011) of follow-up research on various aspects and issues of Maya health care in Nima’ and other highland communities in which K’iche’, Tz’utujil, and Kaqchikel are spoken (Harvey 2006a, 2006b, 2008a, 2008b, 2011, 2012). I use a pseudonym for the town where this research was undertaken because of a moral and ethical obligation to carefully guard the anonymity of study participants as well as the cooperating agents and agencies who graciously shared both personal and sometimes extraordinarily controversial health care–related information. My descriptions of distinguishing characteristics of the people and town are, therefore, intentionally guarded and are perhaps less specific than some readers of ethnography may be accustomed, but that does not compromise scientific rigor or richness of data.

Taking the study of language use in health care as its focus, this investigation of the unheard voices of indigenous wellness seeking
explores both Maya intracultural therapeutic and cross-cultural biomedical interactions in Nima', Guatemala, with the aim of uncovering the cultural and linguistic factors that complicate cross-cultural medical care. This focus on Guatemala moves conventional linguistic and medical anthropological studies of doctor-patient interactions beyond canonical Western biomedical clinical encounters (the focus of much of the existing research) and into under investigated non-Western domains of health care often relegated to the anthropology of religion or overlooked altogether as nonmedical interactions.

Initially unaware of the analytical challenges that lay ahead, I began with the applied aim of discerning how K’iche’ Maya ways of speaking about and expressing ideas related to wellness, illness, and care were communicated, interpreted, and in some cases confounded in disparate and disputed fields of care. These objectives generated a series of seemingly straightforward questions. What are the background assumptions of K’iche’ and nonindigenous health care professionals about wellness, illness, and care? How does each side believe a curative encounter should be carried out? How does the coming together of these different belief systems and communicative styles lead to less efficient health care communication and provision despite the best intentions? However, I soon discovered that in health care interactions in Guatemala between (Ladino) physician-(Maya) patient and (Maya) healer-(Maya) wellness seeker, the conventional Western practitioner-patient pair was all but replaced by models of participation closer to that of group consultation. The sheer number of participants and their (multivoiced) communicative contribution to consultations required the development of new analytical approaches, carrying what began as an applied work into questions of theory and method that ultimately brought about what I call the “the ethnography of polyphony.”

An overview of that literature on the topic of doctor-patient communication in Mesoamerica shows that studies on the dynamics of wellness, illness, and health care among Maya peoples of southern Mexico, the Yucatan, and Guatemala have primarily taken the form of sociocultural and medical anthropological approaches (e.g., Redfield and Villa Rojas 1934; Adams 1952; Adams and Rubel 1967; Mendelson 1967; B. Douglas 1969; Fabrega 1970, 1971, 1972; Fabrega and Silver 1973; Logan 1973; Press 1975; Young and Garro 1981; Orellana 1987; Berlin and
Jara Astorga 1993; Jordan 1993; Lueber 1999). While some researchers have explored problems of cross-cultural medical care in their work on the Maya peoples of Guatemala (e.g., Holland 1962; Gonzalez 1966; Woods and Graves 1973; Annis 1981; B. Tedlock 1992b; Cosminsky 2001; Hurtado and Sáenz de Tejada 2001; Adams and Hawkins 2007), few have made communication their primary focus for examining Maya peoples’ ideas about wellness, illness, and care of the sick (see Cosminsky 1972; Maxwell 1985; Harvey 2003).

Those investigations that have included discussions of cross-cultural medical encounters (e.g., Adams and Rubel 1967; Blaco 1974; Anderson 1981; Balderson 1981) have primarily been macro-level analyses concerned with demographic surveys of indigenous health practices and statistical analyses of national nutrition, morbidity, and infant mortality rates (Pansini et al. 1980; Dominguez 1983; Longchamp 1984; Adams and Hawkins 2007). As a result, these studies provide little insight into the (micro-)interactional workings of cross-cultural care or medical communication. In southern Mexico and Guatemala, historically, the anthropological project has tended to lend its focus to “traditional” Maya (indigenous) beliefs (e.g., Redfield and Villa Rojas 1934; Oakes 1969; Bunzel 1981; Nash 1967; Wisdom 1977; Coe 1984, 1992; Vogt 1990; B. Tedlock 1992a, 1992b; R. Wilson 1995; Villatoro 1999; Cook 2000; Molesky-Poz 2006; Hart 2008).

Similarly, linguistic inquiries into Maya languages have focused on formal descriptions of Maya phonology, morphology, syntax, and semantics (e.g., Edmonson 1960, 1973; Edmonson and Andrews 1985; Laughlin 1975; McClaren 1976; England 1992; Hanks and Rice 1989; Maxwell 1996; Danziger 2001) and less on cross-linguistic interactions (see Garzon et al. 1998; Lewis 2001; Hanks 2010). Those sociolinguistic investigations of Maya languages that have examined cross-linguistic communication have been in the area of discourse and conversation analysis (Metzger and Williams 1963; Bricker 1993; Gossen 1993; Stross 1993; Haviland 1977; Burns 1980; D. Tedlock 1983, 1987; Hanks 1990, 1996, 1999). Within linguistics there is, however, an extensive body of literature on cross-cultural (mis)communication (e.g., Hall 1964; Basso 1972; Philips 1972; Gumperz, Jupp, and Roberts 1979; Gumperz 1982a, 1982b, 1982c; Erickson 1979; Erickson and Shultz 1982; Tannen 1990; Kagawa-Singer and Kassim-Lakha 2003). While these studies do not
specifically focus on Maya cross-cultural medical interactions, they do provide an essential basis from which to depart into an investigation of such issues.

Outside the Maya area, research that concurrently approaches the medical as well as the communicative aspects of cross-cultural medical interactions has come from both linguistics and medical anthropology (see M. Davis 1966; Francis, Korsch, and Morris 1969; Shuy 1974; Labov and Fanshel 1977; Ley 1983; West 1983, 1984a, 1984b, 1984c; Mishler 1984; Martin 1992; Fisher and Groce 1990; Ainsworth-Vaughn 1992, 1998; Fisher 1998; Heritage and Maynard 2006) and has been conducted primarily within the United States with speakers of English as a first language (for some exceptions see, for example, Hein and Wodak 1987 [Austria]; Weijts 1993 [Netherlands]). While offering important theoretical and methodological approaches to analyzing medical discourse, these studies are missing the cross-cultural component needed to study transcultural health care.

Beyond this research on medical communication there is also an emerging body of work outside of anthropology that examines cross-cultural medical communication (Díaz-Duque 1988; Davidson 1998; Elderkin-Thomas, Silver, and Waitzkin 2001; Johnson et al. 2004a; Aranguri, Davidson, and Ramirez 2006; Garrett et al. 2008; Hsieh, Ju, and Kong 2009). Much of this scholarship has emphasized the particular kinds of communicative issues confronting Latin-American migrant farm workers who come into contact with English-speaking biomedical health care professionals. For example, in their research, Ozzie Díaz-Duque and Brad Davidson, based in the United States, have been concerned with identifying linguistic obstacles to medical communication and focus heavily on medical interpreters as cultural/linguistic intermediaries.

The early work of Díaz-Duque and Davidson, while valuable and groundbreaking for its cross-cultural focus, analyzes Spanish/English medical interviews, and they conducted their investigations in those languages. However, for a significant portion of U.S. migrant laborers (e.g., indigenous southern Mexican and Guatemalan migrants), Spanish can be a second language that is often imperfectly learned. This introduces additional challenges to those seeking to provide cultural and communicative competence in biomedical care. Despite such difficulties,
answering the call to competence in cross-cultural care cannot amount to the unrealistic expectation that health practitioners commit themselves to the endless accrual of languages and cultural inventories that match their patient populations (Harvey 2008a). As this book hopes to demonstrate, one anthropological solution to understanding complex variations in wellness seeking within a given patient population would be ethnographic investigations that follow medical communication in those communities beyond the contextual confines of clinics.

By limiting the definition of “medical” communication to clinical encounters, researchers have unintentionally excluded the various meaningful ways in which patients talk about wellness and illness outside of medical interactions and in so doing have overlooked the everyday cultural and linguistic practices that most inform clinical interactions. The more inclusive approach adopted here borrows important lessons and insights from the work of previous researchers and seeks to fill some of the remaining gaps in our understanding of cross-cultural medical interactions with an ethnographic case study of medical communication in Guatemala. Mindful of the applied potential of this work’s findings, this book is not just aimed at an anthropological readership but also offers medical and health care audiences important opportunities to learn “how others see them” by including the varied perspectives of Maya wellness seekers who have shared their experiences accessing biomedical care in Guatemala (see chapters 3, 5, 6, and 7).

**APPROACH**

This study situates itself geographically in the K’iche’-speaking region of Guatemala and makes Maya language both the object of inquiry and the language of investigation. The book follows a project design that combines scientific and humanistic approaches from linguistic, medical, and sociocultural anthropology to comparatively examine the way Maya peoples talk about wellness, illness, and care in intracultural therapeutic and cross-cultural biomedical interactions. The flexibility of this approach enabled me to follow often-elusive indigenous expressions of illness experiences through the diverse and disputed ethnographic terrains of therapeutic interactions between (Maya) healer-(Maya) wellness seeker and (Ladino) physician-(Maya) patient biomedical encounters.
During ethnographic data collection, I systematically observed and recorded (using both audio and, when appropriate, video devices) dozens of curative encounters and the multitude of illness experiences expressed therein for the purpose of comparative ethnographic discourse analysis. These diverse restorative scenes included the burning of offerings on sacred mountainsides by Maya shamans for the health of wellness seekers; the performing of bioenergy examinations on “stand-in” wellness seekers by Maya healers in the treatment of the physically distant sick; the delivery of propitiatory prayers and offerings to sacred effigies by shamanic priests on behalf of wellness seekers; the ritual revelation of itzbal (i.e., the instruments and actions of evil) by diviners in the treatment of malevolently dispatched spiritual and physical ailments; the offering of prayers by the Catholic Church at the homes of wellness seekers; and biomedical vaccination campaigns by Ladino health professionals as well as treatment of Maya patients by them.

The data obtained from recordings and observations in the various health care and wellness-seeking contexts were comparatively analyzed through a model known as ethnographic discourse analysis. In it, text-based transcription methods are combined with ethnography-based annotations of recorded materials. The result was a qualitative and quantitative analysis of the variability in wider cultural and linguistic patterns outside of biomedical encounters that inform and organize language and comportment practices within biomedical interactions.

Because expressions of illness were not limited to formal remedial interactions, using an approach grounded in the ethnography of speaking (D. Hymes 1962), I documented how K’iche’ communicative and comportment practices (vis-à-vis wellness, illness, and care for the sick) were expressed in other aspects of culture and sociality observed in Maya spirituality, rituals, public celebrations, storytelling, and symbolic systems. Whenever possible these observations (audiotaped and, when appropriate, video recorded) were complemented and clarified by follow-up ethnographic inquiries (conducted in K’iche’ and Spanish) with study participants. Aiding me throughout the task of gaining access to and making recordings of sacred (Maya) and secular (biomedical) curative encounters and in conducting the follow-up ethnographic inquiries were most notably my research assistants, the town’s Catholic priest,
local Maya *ajq’ijab’* (day priests/shamans), *ajkunab’* (healers), Ladino biomedical health professionals, and the Nima’ townspeople.³

With observations and recordings of K’iche’ intracultural therapeutic and cross-cultural biomedical communicative interactions as the locus of inquiry, I traced the dialectical relationship that these contextually specific patterns and functions of speaking have with the everyday pattern and functions of speaking that organize the use of language in the conduct of social life (D. Hymes 1974; Bauman and Sherzer 1989). Field techniques involved asking participating (Ladino) physician-(Maya) patient and (Maya) healer-(Maya) wellness seeker as well as their respective companions in care for permission to audio-tape (and video record when appropriate) their cross- and intracultural curative interactions. When possible, following each recorded remedial interaction I and/or one of my research assistants accompanied the biomedical patient or therapeutic wellness seeker, observing the ensuing communicative interactions that they engaged in with their companions, members of their family, and community, linking these patterns and practices of speaking about illness, wellness, and care to others that are expressed through Maya spirituality, rituals, storytelling, myths, and other symbolic systems.

Portions of K’iche’ participants’ recorded cross- and intracultural interactions were transcribed and annotated, providing a bidirectional contrastive analysis of K’iche’ speech activity in numerous contexts (see Goodwin and Goodwin 1987, 1992). Using ethnographic discourse analysis, relevant portions of annotated transcripts were closely examined for emerging codable patterns (e.g., misunderstandings, repairs, laughter, turn taking, pauses, topic transitions, questions, timing, loudness, subtle connections to past and subsequent discourse, indices differentiating public, private, intimate, and distant speech) that relate to consistent characterizations of the ways (Ladino) physician-(Maya) patient and (Maya) healer-(Maya) wellness seeker (and their companions) talk about wellness, illness, and care (see Tannen 1989; Schieffelin 1990). I drew on the contrasting data contained in these analyzed transcripts of biomedical and therapeutic interactions along with the ensuing sociolinguistic data obtained by accompanying K’iche’ participants after their interactions to arrive at an understanding of, for example, the way topics are introduced, maintained, and closed, the organization of
turns of talk, appropriate and inappropriate interruptions, what forms questions take, what counts as an answer, and what the ties are between stories and the preceding conversations (see Briggs 1986; Spradley 1970, 1979, 1980).

Using annotated transcripts and sociolinguistic data as a guide, I conducted follow-up ethnographic inquiries with study participants. The inquiries asked each member of cross-cultural biomedical and intracultural therapeutic group questions about the relative intelligibility, comprehensibility, and interpretability of relevant portions of their co-constructed biomedical or therapeutic experience. The aim of this systematic observation, recording, and comparative analysis of intracultural therapeutic and cross-cultural biomedical encounters was to understand how the sociolinguistic conditions governing appropriate speech activities in biomedical encounters differ from or were similar to those that govern K’iche’ verbal participation in therapeutic encounters and other community-wide communicative performances.

OVERVIEW OF CHAPTERS

Chapter 1, “Between Belief and Relief” begins with an apologue in medias res with a Maya illness narrative composed of the multiple voices and pluralistic experiences of participants in this investigation. It introduces readers to Maya intracultural therapeutic and cross-cultural biomedical care in Guatemala by providing them with an ethnographic sense of the sociocultural scene within which K’iche’ Maya peoples express their ideas about wellness, illness, and caring for the sick. Many of the issues and questions raised by the details that the narrative omits with regard to the way Maya peoples talk about wellness, illness, and care are intentionally left unresolved in chapter 1. The composite narrative of Maya wellness seekers, told in a manner that seeks to reflect the multivoiced quality of Maya storytelling, is organized so as to foreshadow some of the primary issues and problems that are identified, described, and examined in the ensuing chapters.

Chapter 2, “The Ethnography of Polyphony” is presented by way of a conventional disciplinary dialogue that outlines the principal problems that confront a linguistic anthropological project that seeks to study communicative interactions as both the objects of scientific inquiry
and the lived experiences of full-fledged subjects. Interspersed within the discussion of the problematic of conventional methods and techniques for analyzing communicative interactions is a description of an alternative approach developed here, “the ethnography of polyphony,” which was inspired by the unique challenges that K’iche’ polyphonic interactions presented to conventional methods of linguistic transcription and discourse analysis. Finally, arguments are presented in favor of the use of “polyphonic scores” over conventional transcripts for presenting and analyzing interactional fields involving multiple participants, demonstrating what conventional transcripts conceal and what the polyphonic scores reveal about the nature and composition of communicative interactions.

Chapter 3, “Which One of You Is the Patient?” launches the examination of language use in health care in Guatemala. It applies the ethnography-of-polyphony approach to a cross-cultural biomedical consultation at the centro de salud (health center) in Nima’, Guatemala, between a Ladino (Hispanophone) physician, a Maya wellness seeker, her baby, and two companions. The chapter describes the ethnographic scene surrounding care for the sick at the centro de salud, and techniques of the polyphonic approach are laid out in further detail. Using the polyphonic score, I analyze a cross-cultural biomedical consultation according to the principles of the ethnography of polyphony described in chapter 2. The analysis identifies the salient characteristics of (Ladino) doctor-(Maya) patient medical interactions, describing the sociolinguistic practices common to the role of Ladino physician, Maya wellness seeker, patients, and companions of the wellness seeker. It also discusses the expectations implicit in the sociolinguistic roles of clinical participants (e.g., physician, patient, wellness seeker, and companions) that tend to predictably complicate communication in biomedical interactions.

Chapter 4, “The Roar on the Other Side of Speaking” takes the analysis of the centro de salud consultation discussed in chapter 3 beyond a speaking-centered approach, analyzing communicative interactions and exploring what lies on the other side of interactants’ speaking. This chapter examines the contributions of interactants’ “communicative
silences” to the composition and meaning of communicative interactions. The findings call for a reconsideration of silence, one that argues that silence in interaction be considered a communicative “act,” that is, a form of doing. With this aim, chapter 4 offers a preliminary sketch of the discourse roles that “making silence” play in communicative interactions and then reexamines the centro de salud consultation discussed in chapter 3, describing the communicative functions of silence in it. The analysis demonstrates that what happens in the background, on the other side of speaking (i.e., making silence), can be as significant to the production and sharing of meaning in communicative interactions as the speaking that populates the foreground.

Chapter 5, “A Call to Competence” takes the scientific study of language use in health care beyond the contextual confines of the Western clinic, doctor-patient interactions, and biomedical health care and into linguistically understudied therapeutic fields of care like Maya healer-wellness seeker interactions. The chapter begins by describing the ethnographic scene surrounding Maya therapeutic care for the sick. Utilizing the polyphonic approach, I examine a (Maya) healer-(Maya) wellness seeker intracultural therapeutic consultation at the dispensario (dispensary) in Nima’, Guatemala. Through this examination of a dispensario consultation, I am able to identify and describe some intracultural communicative and comportment practices of the K’iche’ Maya that are sociolinguistically characteristic of Maya ways of expressing wellness and illness in therapeutic care and that contrast with communicative expectations and practices observed in biomedical interactions in chapter 4.

Chapter 6, “Wellness Made out of Words” discusses specific aspects of the sociolinguistic roles of Maya healers, wellness seekers, and their companions that inform their interactional strategies in therapeutic consultations and express their sociolinguistic expectations of what a remedial encounter should be. It compares and contrasts the sociolinguistic practices for eliciting and giving out information regarding wellness, illness, and care in cross-cultural biomedical consultations with those seen in Maya intracultural therapeutic interactions. In this section the medical interview as a speech event common to biomedical
consultation is compared to Maya narrative answering, a speech event common to Maya storytelling and therapeutic consultations. This chapter also discusses the possible effects that these culturally distinct ways of interacting have on the outcome of care for those Maya wellness seekers who do not possess equal communicative competence in indigenous therapeutic and biomedical interactional styles.

Chapter 7, “Vaccinated Voices” is an ethnography of Maya voices on the subjects of wellness, illness, and care that unfold beyond the clinical context. This section explores the largely undocumented experiences of Maya wellness seekers who find themselves caught in sometimes violent medical disputes raging between secular and sacred models of care: Ladino biomedical agents and agencies, on the one hand, and Maya therapeutic agents, on the other. Specifically, the chapter examines the sociocultural controversies that have sprung up around one medical practice in particular, vaccinations, and it traces the problems and complexities in cross-cultural biomedical care that such contested practices have produced. The discussion of these curative disputes, or what might be critically called a kind of biomedical neocolonialism, moves from a microanalysis of the communicative strategies used by nurses at the centro de salud to coerce vaccination compliance to a macroanalysis of vaccination campaigns in remote cultural areas in the search for patients among the medically unreached, alleged vaccination violence committed against children, medical efforts aimed at secularizing Maya birth and birthing, and long-term sociomedical efforts aimed at subtly “disabusing” Maya groups of some of their fundamental ideas about the nature of wellness, illness, and care by replacing Maya (indigenous) therapeutic care with biomedical care.

The epilogue, “Vital Voices,” offers some concluding remarks on the study of language used in health care in Nima’, Guatemala. It reiterates salient and subtle issues raised in the discussions of Maya intracultural therapeutic and cross-cultural biomedical interactions. Methodologically consistent with the polyphonic approach to ethnography, my closing remarks do not attempt to offer a homophonic (single-voiced) summary of the work. A monologic conclusion of the interactional circulation of meaning between multiple voices and pluralistic experiences
would have the effect of supplanting the privileging of the very points and counterpoints made by variations in participants’ voices. By holding a monologic conclusion in abeyance, I have attempted to create a transformative space in the ethnography of polyphony that invokes the indeterminacy of living experiences in socioscientific research design, methodology, and analysis. In this way, the epilogue takes its cue from K’iche’ Maya storytelling, offering remarks that are concluding but not totalizing.

**A NOTE ON ORTHOGRAPHY**

The basic unit of analysis for this investigation is communicative interactions. To textually present these on the page, the book utilizes a K’iche’ orthography standardized collaboratively by Maya and North American linguists at the Proyecto lingüístico Francisco Marroquin in Guatemala. Because my approach to the written presentation of Maya language use (with regard to pronunciation and grammar) is descriptive rather than prescriptive, when necessary, I have modified the standardized orthography to reflect the idiosyncrasies of speakers’ pronunciation. Moreover, utterances (in K’iche’ or Spanish) are transcribed to reflect (descriptively) a speaker’s actual use of grammar rather than edited (prescriptively) to reflect the rules of grammar.

Though the descriptive approach in linguistics is far from novel (see, for example, William Labov’s famous treatment of African American inner-city speech styles [1972]), it has its opponents. Some see representing the idiosyncrasies of speech and grammar (especially in minority groups) as problematic if not inappropriate because it is thought to present them as somehow communicatively lacking or otherwise undereducated. Given that this presumption of “lack” is based on perspectives that privilege school literacy over other ways of knowing, it amounts (ironically) to ethnocentrism. Here, orthographically presenting the voice of others in their own native orthographies reinforces a view of the K’iche’ language (and Maya languages in general) as standard and indeed scholarly.

**TRANSLATIONS**

Great care was taken to accurately translate the communicative contributions of all of the participants in the investigation. All translations
were undertaken in the field in collaboration with at least two native-K’iche’-speaking research assistants and when necessary, in direct consultation with participants in the investigation. Translating meaning across multiple languages is more accurately described as the work of interpretation because one-to-one equivalences are rarely attainable. In this study, the task of translation was made more laborious by the fact that Maya speakers of Spanish as a second language did not always grammatically express in Spanish (if one were to translate directly) what they themselves intended or what others present understood them as having intended. Interpretations, therefore, frequently involved follow-up interactions with participants to determine not only what a given speaker meant but what others who were present understood. Readers are also reminded that because this work is linguistically descriptive rather than prescriptive, would-be spelling and grammatical errors sometimes observable in the K’iche’ and Spanish polyphonic scores reflect speakers actual use of the language rather than mistakes.

OMISSIONS

In an effort to protect the anonymity of participants, all of the personal names of participants have been changed to pseudonyms and their identifying characteristics omitted. Moreover, because some of the topics involve controversial issues and questionable health practices, the place names have also been changed to protect the privacy and respect the confidences of the patients and health practitioners who graciously agreed to participate in this study.
I

BETWEEN BELIEF AND RELIEF

Apologue of Maya Wellness Seeking In Medias Res

Hidden in the shaman’s prayer, lurking in the sorcerer’s contagious stare, and in the afterglow of the healer’s sympathetic care—the still twittering voices of magic and religion. Dare we give the voices chase, follow them into Fraser’s thicket to face the aged figure beneath the Golden Bough? Ask—not aloof, but beside Evans-Pritchard and the Azande with the ruins of that old granary and the human life at our feet—“why?” not “how”?


MAYA WELLNESS SEEKING IN EVERYDAY LIFE

After a two-hour bus trip, Xuan and Per finally reached the western highland market of San Francisco el Alto. Their small child, Tun, had been sick for three days, but the family hadn’t taken him to the clinic yet because they desperately needed any money that they might earn from sales made at the regional market. When they arrived at San Francisco, Xuan stayed back by the buses, looking for a spot among the other men to setup a display for his handmade axe handles. Per, with little Tun strapped securely to her back and bundle of vegetables balanced atop her head, went up the hill toward the market to find a place under the low-hanging colorful tarps that lined the market’s streets where she could sell her produce.

As little Tun lay against his mother’s back, enfolded in the woven womb of her tzut (carrying blanket) his mother could feel his every movement and he hers. As she recalled, he did not seem to be comforted that day by the sound of her heartbeat or the warmth of her body. He groaned and squirmed with a kind of sustained agitation that worried her and Xuan. To lessen his discomfort Per reached her hand
around her back and lovingly patted him on his underside while gently bouncing him up and down, saying in a low voice, “Sus . . . jas uwach ri uyab’?” (“Jesus, what is the essence of his illness?”). On the other side of the market, Xuan patiently watched as shoppers walked by his neatly displayed axe handles that lay on the ground before him. He, too, was wondering what could be wrong with their firstborn child. “La xub’an umak?” (“Had he sinned?”) “La xub’an jun ch’o’j?” (“Had he mistreated anyone?”) “La xuk’ia kre’j?” (“Had he wanted something or envied someone in an excessive way?”). Could it have been the snarling of the non-cat (a sorcerer’s companion spirit) on the rooftop the week before? Why had his son met with sickness? A few feet away at the busy intersection, Xuan could hear the voices of traveling medicine men over loud speakers, roaring above the noise of buses, soaring over the market.

Between “traditional” healing and modern bio-medical care, straddling the public and the private, the local and the global, stands Maya mobile medicine in Guatemala. Traveling Maya medical salespeople—whether on “soapboxes,” over loudspeakers in open air markets, up and down the aisles of crowded buses, or in town squares—are everywhere, yet knowledge of their health messages, goods and services is missing from the socio-scientific literature that stretches from anthropology to bio-medicine. (Harvey 2011)

Beyond the church, Per managed to find a dry spot for her and Tun under the makeshift tarps that hung above the market’s outer walls. After painstakingly arranging her display on a colorful piece of plastic on the ground and organizing the tomatoes and green peppers, she began nursing Tun and waiting for customers. Amid the clamor of bartering voices, the low cries of babies, the sounds of laughter and the infrequent squeals of animals, Per overheard an older woman a few displays away giving someone advice on how to relieve a child’s stomachache.

Judging from the design of the older woman’s po’t (handwoven blouse) Per suspected that she was from the town of Chiquimula, and so surely the woman would know the current Nima’ Catholic priest, a K’iche’ Maya who was born and raised near Totonicapán. As they began
to talk Per learned that the woman was an iyom (midwife) and an old friend of Padre Geronimo’s family. After conversing for some time, in between selling goods, they managed to slowly reconstruct the likely scenario that had produced Tun’s troubling illness. Per recalls that the midwife suspected itzbal and recommended that she select and prepare four kinds of herbs to be given to Tun and to be taken by Per and her husband Xuan in conjunction with their making prayers and propitiatory burnt offerings.

The family left the market at San Francisco in the cool of the evening and on the long bus ride home there came a health announcement over the radio that broke the blasting of a melancholy musica ranchera (Latin country music) song. They had heard many such announcements before but had given little notice. Through the static of the radio and the roar of the unmuffled diesel engine there came the voice of a K’iche’ woman in the darkness saying,

Nan in wa in ilonel. Jas ib’anom chwe le ri choch la? O pa ri k’ayib’al, camioneta, jaw chin ch ne karich’ b’alaj la, xa kinya jun no’oj la? Are taq le ala, t’axnob’, alanqik, kasi le uqul k’ax, k’o nim sib’abalaj q’aq’. Trij la kraj ne, ko jun jiq’ aj oj. Naj taj kawib’aj, chika ma’ lo rib’ pa hospital, pa le centro de salud, o ruk’ jun ajkununel, utz lu woch kawiej ta na, kcam chwach. (Ministry of Public Health radio announcement 2001, Guatemala)

(Mother, this is your midwife speaking. What are you doing in the house? Or are you in the market, or you are maybe listening to me on the bus? Wherever you can be found, I just want to give you my council. When your child catches a cold very quick, has difficulty breathing, a sore throat and he has fever, be careful. He could possibly have pneumonia, so don’t wait any longer! It is urgent that you go to the hospital, the emergency care center, or the health center. Don’t put the life of your child at risk.)

The woman seemed to speak directly to Per; how did she know that they had been to k’ayib’al (market) or that they were on the camioneta (bus)? Maybe the woman knew something? Having visited an ajq’ij and
a theurgical herbalist back in Nima’, Xuan and Per began to wonder if they might benefit from going to their local centro de salud. They had heard from Maya healers and town laypeople alike that the services and practices of Ladinos at the centro de salud were questionable, and there had been that dreadful occasion when health practitioners came to vaccinate in Per and Xuan’s village. Taking Tun to the hospital in Xela (an abbreviation of K’iche’ Maya city name, Xelaju, also referred to in Spanish as Quetzaltenango) was out of the question because everyone in Nima’ knew that people who went there often came home dead. There was a similar sentiment about the emergency care center (“You wait forever and they charge a lot”), so this was not an option either. And though the announcement had come from a K’iche’, and a midwife at that, Xuan and Per still felt a little uneasy about going to the centro de salud. As Xuan pointed out, it was obvious from the way that the woman spoke the ch’ab’al (language) that she was not from their village. She was likely from Momostenango. They wondered if her tz’ij (word/truth) could be trusted.

CHOOSING CLINICAL CARE

Early Monday morning after Xuan had eaten and left for the milpa (cornfields), Per with Tun on her back went over to her cousin Talin’s house to see if she could accompany them to the centro de salud. Talin was missing a day of school so that she could accompany Per and Tun, and the three of them headed down the mountain to the centro de salud. Once there, they waited in line to check in, and after some time, they reached the front desk, where the receptionist asked “¿Quién va a recibir la consulta?” (“Who is going to receive the consultation?”) Talin, who was in grade school and spoke more Spanish than Per, responded, “Xper Sop Xik,” giving her cousin’s full name, like she had learned in school. After receiving a numbered piece of paper, they waited for Per’s name and number to be called, sitting among the women and children on the long benches that were affixed to either side of the clinic’s hall.

The quiet conversations of women and the cries of children filled the hall as the visitors waited for consultations. After about a half hour or so, when all of those receiving morning consultations were seated, a well dressed K’iche’ man who was about eighteen years old emerged at the far end of the hall bearing posters under his arms. Raising his voice
above the commotion, he warmly greeted the visitors with a smile, saying, “Saqarik nan. Saqarik alitomab” (“Good morning ladies/mothers. Good morning young/unmarried girls”).

After introducing himself and explaining that he was a health promoter he proceeded to give the daily health announcement in K’iche’. On this particular day the topic was “planificación familiar” (“family planning”). For ten minutes the captive audience of Maya wellness seekers were, to use the language of health practitioners, “educated” in the virtues and values of having a small family of one or two children. As the young man spoke, the women periodically leaned over to one another, covering their mouths with their hands and whispering to each other while keeping their eyes fixed on him. Undistracted by the constant chatter and the movement of children, the Maya health promoter illustrated the announcement with brightly colored posters bearing the likeness of the various contraceptives and assorted paraphernalia available at the centro de salud for planning a family.

To be persuasive the health announcement was designed to appeal to what the health professionals and researchers said were Maya cultural and socioeconomic sensibilities. As if speaking from a kind of guidebook to Planned Parenthood, the promoter told the group of Maya women and adolescent girls that to have fewer children was ultimately beneficial because it would mean having more resources at home to be distributed between fewer people. The message was simple; have fewer children, and those that you do have will be healthier because you will have more resources to care for them and thus, you will all have a better life in general.

Having too many children was offered as a partial impromptu explanation for the economic woes of Maya peoples. The announcement ended with an impassioned plea to the women to ask the nurses for more information about family planning and the suggestion that they discuss the advantages of birth control with their spouses. A few of the women that were present later recounted that they remembered thinking that the talk about “the pill” and having fewer children was unsettling. How could they tell their husbands? The talk seemed to confirm what their husbands and fathers had been warning them about; principally, that the centro de salud and Maya health promoters by extension were secretly working with the Guatemalan government to sterilize or
otherwise “disappear” the Maya with “the pill” and vaccinations (see Green 1999; Nelson 1999; Short 2007).

When Per’s name was called, she, Tun, and Talin entered the pre-consultation room where they were given a preconsultation by Victoria Gomez, one of the Ladina auxiliary nurses. Per’s cousin began by telling the nurse that both she and the baby were ill. Ms. Gomez explained to Talin that if she wanted a consultation she should have gotten a separate slip with her name on it from the receptionist at check-in. Though Talin seemed to accept this explanation, she later said that she did not understand why only the baby could receive a consultation when all three of them had been waiting.

The nurse asked Per, with Tun still fastened to Per’s back, to step onto the scale. When Victoria had written down their weight, she asked Per to hand her child to her companion. Carefully untying the ends of the woven tzutz that symbolically crossed her heart where they fastened, Per handed Tun to Talin, and the nurse reweighed Per to deduce the weight of the child. As the nurse was recording the weight she looked up from her writing and asked, “¿Y . . . cuantos años tiene Xper?” (“And . . . how old is Xper?”) Talin and Per burst into laughter as they responded, “Viente-tres años” (“Twenty-three years old”). Ms. Gomez’s embarrassment showed; she had simply read the receptionist’s slip where Per’s name was written and thought that Xper was the child. Though the nurse had noticed that the child was not a girl what she did not know was that in K’iche’, Per, short for Xper (Isabel) is a female’s name. Ms. Gomez awkwardly laughed along with them, explaining that what she really wanted to know was the age of the child.

MEDICAL DISPUTES, REPRIMAND, AND COERCION

After making changes to the clinical record, the nurse asked Talin to let her hold the baby for a moment. The nurse removed the woven blankets that were carefully wrapped around Tun, stretched his little body out, and laid him flat on the wooden measuring table. He began to moan, but within moments he was back in his mother’s arms and nursing, which seemed to make him forget that he was ever upset. But Tun’s calm was short lived. The nurse suspected from touching his body that he had a fever and asked Per to lay him across her lap with his backside up so that his temperature could be taken. Once on his stomach, a thermometer
was lubricated and inserted into Tun’s rectum. The nurse, seeing that Tun had recently relieved himself, said sternly to Per, “Ay . . . Mija! Hay que mantener su hijo limpio. Por favor” (“Oh . . . My daughter/child! You have to keep your boy clean. Please!”).

On his stomach, Tun quickly grew irritable and cried relentlessly. When Per managed to comfort him a bit by rocking him up and down on her lap the nurse told her that she needed to place one hand on the thermometer and keep him steady. Tun quickly responded to his mother’s altered movements with new tears. Per and Talin looked anxiously at the nurse as she wrote, waiting for her to remove the thermometer. Some time after the experience Per mentioned in conversation that she thought that placing Tun face down with his head hanging off her lap and putting a piece of glass up his rectum was no way to treat a baby. She said, “I only agreed to do it because I wanted him to be well.”

While waiting for Tun’s temperature reading, the nurse opened the door to the hall and called the name of another patient. Soon after, a middle-aged woman entered the consultation room with three children in tow. Amid the commotion the nurse, looking as if she had forgotten something turned and asked, “¿Tienes su tarjeta de vacuna?” (“Do you have his vaccination card?”). “Sí” (“Yes”), responded Talin, but Per looked puzzled, so she asked her “La k’o le wuj?” (“The paper, is it here?”). “Ma wetaman taj . . . xaq xuwi” (“I don’t know . . . only”), answered Per, but before she could complete her utterance Talin quickly assured the nurse that they had Tun’s vaccination card, explaining, “Está . . .” (“It is . . .”), as Per added, “En la casa” (“At the house”).

Again, the nurse reprimanded them, saying they would have to learn to be responsible and to bring their paperwork with them to every clinical visit. She added that without proof of vaccination the centro de salud rule was that no one could receive a consultation with the doctor. “Pero ya lo puso” (“But you already administered it”), Per retorted in a low voice. “Cuando usted llegó a nuestra casa” (“When you came to our house”), Talin joined in. The nurse did not respond but instead pointed out that there were other people waiting for their consultation. She urged Per and Talin to either have Tun vaccinated again or go home without having seen the doctor after waiting for three hours. Talin mentioned again that she felt sick, telling the nurse, “Yo tengo mi tarjeta” (“I have my card”). “¿Puedo ver el doctor?” (“Can I see the doctor?”).
nurse replied, “I’ve already told you, if you wanted to see the doctor you should have gotten a slip from the receptionist.”

Later the nurse remarked on this exchange and the *centro de salud*’s approach to vaccinations. She explained that in general, they do not believe Maya patients when they say that they have vaccination cards at home or when they claim that they or their children have already been vaccinated. According to her, *centro de salud* practitioners agreed that these explanations were merely excuses that Maya patients made because they were “uneducated, unwilling, or afraid to be vaccinated.” Given this presumed clinical truism and the idea that the mission of the *centro de salud* was to provide health, the unofficial policy of the practitioners was “when in doubt, vaccinate.”

After a few tense moments Per and Talin conceded to the vaccination. Tun was carried behind the white sheet that bisected the room, separating the office space from the nurses’ examination area. There, with the hands of his mother and cousin touching him and their voices whispering low in K’iche’, Tun let out a great scream that escaped the room and roamed the hall, as the needle broke his skin and the vaccine burned in his blood. “Q’aaq’!” (“Fire!”), Talin cried. “Le, le, le baq tajin kuporoj le wal!” (“The, the, the, the needle/bone is burning my son!”), Per agonized. Like sympathy, a child’s cry is contagious, and Tun’s caught on. The two youngest of the three children who were waiting on the other side of the curtain also began to cry, hiding on either side of their mother behind the protection of her *uq’* (woven skirt). Before returning to her desk the nurse again commented after seeing Tun’s bare backside a second time that Per would have to keep him clean. Per and Talin wondered why the nurse would expect them to bathe Tun today after she had just vaccinated him? All of the townspeople knew that this was something to be avoided.

As Per and Talin gathered their belongings to make way for the other family, the nurse handed them a vaccination card and told them to return to the hall where they would be called by the physician. When asked about their decision to allow Tun to be vaccinated, Per and Talin only said that they thought that it was strange that the nurse did not remember previously vaccinating him. According to Per, the nurse and others from the *centro de salud* had come to vaccinate in their village.
just two weeks earlier during the dreaded *semana nacional de salud* (national health week).

When Per and Talin returned to the hall as the nurse had instructed, Tun’s cries joined those of other children. They began to wonder if they had done the right thing in coming to the *centro de salud*. “It happened so fast,” Per recalled. “Maybe we should have just left,” lamented Talin. Per let Tun play with the small rectangular piece of paper that bore his name. Chewing on it seemed to calm him. About a half hour later, Dr. Francisco called Per’s name. She had already rewrapped Tun in his blankets, and he was drifting in and out of sleep when they entered the doctor’s office. After exchanging greetings and smiles the doctor motioned for them to have a seat on the wooden bench that faced his desk.

The doctor began the consultation, asking, “¿Dime, que es lo que esta pasando a la nena?” (“Tell me, what is it that is happening to the baby?”). Talin answered by explaining that it had rained more than was normal for the time of year and that Tun had taken sick. There had recently been three solid days of rain, and this was around the time that Tun started to groan and become discontented. Without saying that Per had gotten this information from a consultation with a Maya *ajkun*, Talin explained that they believed that it was “wich chikop” (“little animals”) in Tun’s body that made him groan and squirm. The animals had been aggravated by the lightening and intense rain and had begun to move around inside of him, causing discomfort.

**CULTURAL EXPECTATIONS OF CLINICAL EXPERIENCE**

Dr. Francisco listened as Per and Talin took turns talking about Tun and the illness experience, asking a lot of questions and writing things down as they went along. After a short time, the physician’s questions started to make Per uneasy, and she began to doubt his ability to cure. Before going over to examine Tun the doctor asked if he could have a look at Tun while Per held him in her arms. After checking Tun’s eyes, ears, and throat the physician returned to his desk to write. The physician then asked Per if she would uncover Tun so that he could have a look at him over on the examination table.

The doctor’s request made Talin nervous, and she watched to see what Per would do. Per carefully removed the blankets but left Tun’s
clothing and shoes on. As she laid Tun supine on the examination table, she and Talin stood next to him, touching his arms and legs. When Dr. Francisco came over to examine Tun, Talin moved down toward the head of the examination table, allowing Per to make room for the physician beside the examination table. As the three of them stood at the table Dr. Francisco examined Tun, working around his clothing.

Per later happily remembered that the doctor never asked that she remove Tun’s clothing. When, for example, he wanted to listen to Tun’s lungs he simply slipped the stethoscope under Tun’s clothing without ever removing them, a practice that comforted Per and Talin a great deal. Having to remove clothes for a consultation was something that Nima’ townspeople (and women in particular) frequently sited as a bothersome part about going to the hospitals in the nearby city of Quetzaltenango. When Talin’s sister unexpectedly gave birth in a hospital, she recalled that when she was ready to return home she found that her po’t, which she was required to remove during her hospital stay, had been carelessly discarded by the hospital personnel.

Throughout the examination Per and Talin remained by the doctor’s side, maintaining either physical or eye contact with Tun at all times. Only after the examination had been under way for some time did Tun become audibly upset and when he did the doctor was nearly finished. Throughout the exam the doctor spoke to Tun in a “small” voice, congratulating him on doing so well and on being such a good child. He would say to him, for example, “Solo quiero ver tu estomagito. Solo tu estomagito. Muy bien” (“I only want to see your little stomach. Only your little stomach. Very good”). “Solo un momentito mas y ya estuvo!” (“Only a little moment more and already it’s done!”). When the doctor had finished the exam, Per and Talin carefully rewrapped Tun in his blankets and returned to the bench facing the doctor’s desk. Dr. Francisco briefly explained that Tun had both a chest cold and intestinal worms. “Zij” (“Truth”), Per commented to Talin, who agreed, saying, “Areso, le ajkun xub’ij caheve” (“For that reason, the healer said it to you”). The physician told them that when they returned to the hall the nurses would call their name for the postconsultation and explain exactly what they needed to do to care for Tun and give them medication that he needed. The physician ended the consultation by assuring them that Tun would be fine.
After returning to the hall and waiting another half hour or so Per’s name was called again. They then entered the postconsultation room, and the nurse quickly explained Tun’s condition and the restorative treatment regime that they would need to follow. Per later recounted that she didn’t understand much of what the nurse had explained in the postconsultation, saying, “Xaq xuwi xinb’ij je” (“I just said yes”). “Man kinchab’o taj castill” (“I don’t speak Spanish”). The portion of the postconsultation that was the most difficult for Per and Talin to understand was not the medical explanation that the nurse gave for how Tun had become ill, since Per and Talin already partially knew this; rather it was the instructions on when and how much medication to give Tun.

The nurse said that they should give Tun one tablet from one of the white bottles of medicine “dos viajes” (“two trips/times”) a day, once after breakfast and once after dinner. She added, “These pills must be taken after he has eaten, right?” “Yes,” said Per. “That’s right,” confirmed Talin. The nurse later explained that with Nima’ Maya townspeople, they used the term “viajes” (“trips”) instead of “veces” (“times”) because the indigenous people “understood it better.” The nurse instructed them to give Tun one tablet from the second narrower white bottle of medication every six hours. The nurse said, “If you wake up at 6 a.m., you will give Tun one tablet at 6 a.m., and another tablet at 12 noon, and another one at 6 p.m., and one more tablet at 12 a.m.” To verify that they had understood the nurse asked, “So you’ll give him four of these tablets per day because there are . . .” Talin interrupted, “Twelve hours in a day!” “No, there are twenty-four hours in a day, right?” “Yes,” responded Per. “So how many times are you going to give him these pills?” asked the nurse. “Dos viajes” (“Two trips”), answered Per. “Once after breakfast and once after lunch.” The nurse corrected her, saying, “No, you give him these pills four times per day. He doesn’t need food with these pills, he needs food with the other ones, right.” “Right,” said Per. “Yes, of course,” said Talin.

The last medication that they were told to give Tun was cough medicine. The nurse explained that they would give him cough medicine twice a day, once in the morning and once at night. For Per and Talin, when to give the cough medicine seemed fairly straightforward, and
because it was in liquid form it could not easily be confused with the pills. However, they recalled being a little confused about how much cough syrup to give. The nurse said to give him “dos cucharitas” (“two teaspoons”), once in the morning and once in the evening. Per said that when they returned home she remembered when to give him the cough medicine but was not sure how much exactly a “cucharita” was. Neither she nor anyone she knew in Nima’ owned or used teaspoons, so she would have to guess how much a teaspoon was. She only suspected that it must be a small quantity because it was a cucharita as opposed to a full-size cuchara (spoon). Per would have to discuss the dosage and times with Talin, and together they would decide what should be done.

Before they left the postconsultation the nurse asked them if they had considered planned parenthood and “the pill.” She suggested that they not be ashamed or afraid to discuss the matter with their husbands (though Talin was unmarried). The nurse said it was important that they not let their husbands tell them what to do. It was their bodies and they had the final word on whether or not they were going to have children or not.

When the nurse had explained and reexplained the dosages, she told Per that in order to receive the medicines that they discussed she would have to sign their record book. When Per hesitated to sign the book the nurse suspected that she was illiterate and offered her the option of pressing her thumb on the ink pad and leaving her thumbprint on the signature line. Having heard rumors that unsuspecting Maya had been known to lose their land by signing documents that they did not fully understand, Per opted to leave her thumbprint, and like others she knew, when she placed her thumb on the page she dragged it slightly, making the thumbprint indistinct.
2
THE ETHNOGRAPHY OF POLYPHONY
Dialogue of Disciplines (Needful Divigations of Theory)

THE GERUNDIAL WORLD OF SPEAKING AND EXPRESSING
Little if any imagination is needed to envision a world where the multiplicity of our expressions and experiences and of those around us are juxtaposed and counterposed in harmony and discord in the ebb and flow of everyday life. This is the sensing world of full-valued voices and of pluralistic experiences, the lived world. But despite the familiarity that our incessant expeditions into these most human of interactions bring, for the ethnographer of language and culture much of this multiplicity seems to elude description. The operation of ethnographic and linguistic analysis is by conventional application an assimilation of the unmerged “stuff” that constitutes experience, a distilling of full-valued voices and pluralistic experience into “objects” of inquiry. All too often the written descriptions of the speaking and expressing of the full-fledged subjects we encounter and interact with become, through our monologic descriptions and analytical preoccupation with fixity, the scientific artifacts of speech and expression in a textual world of lifeless things and meaning.

This investigation approaches the study of communication as a gerundial (unfolding) world of speaking and expressing, a world where meanings are both lived and living, being and becoming. Here, communicative acts are not treated as a field of motionless objects that can be made orthographically obedient to ethnographic and linguistic scrutiny but as invariably living experiences whose meanings are fluid and unfolding indefinitely into the future. Making the analytical distinction between the fixity of “speech” and “expression” (objects of observation and description) and the fluidity of speaking and expressing (subjects of lived experience) means approaching communicative interactions as three-dimensional. That is to say, communicative interactions are
not only understandable from the distance of scientific observations and descriptions but also from the experiences of those living them firsthand.

Communicative interactions and their emergent meanings, whether recovered in our ethnographic recordings and recollections from the field or lived firsthand, unfold within and before us as a partial scene rather than a total site. It is this gerundial quality, or what Erwin Straus called the “not yet” of speaking and expressing that already reaches into and out of the present, that makes the meanings of interactions both accessible and indeterminate (1963). Here, in the fluidity of meanings, in the unfolding and indeterminate quality of speaking and expressing, the open-ended voices of others elude the “fixity” of monologic descriptions by withholding the “ultimate” meanings of their communicative interactions. Theoretically, this is an important aspect of polyphony (multivoicedness) because it is the withholding of ultimate meaning that denies monologic (authorial) claims to ultimate authority, leaving meanings as emergent.

APPROACHING LANGUAGE AS LIVED AND LIVING

In this study, K’iche’ Maya ways of expressing ideas about wellness, illness, care in intracultural therapeutic and cross-cultural biomedical encounters are treated as unfolding. In practice this means adjusting the focus of our analysis of language use in health care encounters away from static descriptions of the thing-like structures that “figures” of speech, sensations, and expressions imply (i.e., the “what” of propositions) and toward the unfolding, three-dimensional interplay of multiple voices and pluralistic experiences, the speaking, sensing, and expressing “who” of full-fledged subjects. This focus on the “who” of interactions and not merely the “what,” and on privileging the nearness of participation and not merely the distance of the scientific observation is a means of indirectly questioning a position that suggests that “meaningful action is an object for science only under the condition of a kind of objectification which is equivalent to the fixation of a discourse by writing” (Ricouer 1981:203, emphasis mine).

Must meaningful action—in this case communication—be limited to an object for science only under the condition of the objectification, concretization, and quantification of qualitative experience? Might the
study of meaningful action (or communication) also be an object for science under the subjective conditions of the lived experiences of full-fledged subjects? This investigation considers K’iche’ communicative interactions in intracultural therapeutic and cross-cultural biomedical encounters in Guatemala as composed of actions that are meaningful for science, both as the firsthand qualitative experiences of interacting subjects and as the second- and thirdhand quantitative objectifications of observing researchers. In order to approach K’iche’ ways of expressing ideas about wellness, illness and care as a gerundial world (understandable as the unfolding qualitative experiences of full-fledged subjects), we must be willing to follow rather than fix the multiplicity of voices, experiences, and meanings encountered in the diverse recordings, observations, and experiences from the field. Such a pursuit of the indeterminate and unfolding life of communicative interaction requires a socioscientific approach that possesses a degree of what Keats called “negative capability,” a modus operandi that permits and indeed anticipates uncertainties, mysteries, and doubts.¹

**POLYPHONIC APPROACH TO MULTIVOICED INTERACTIONS**

As the ethnographic and linguistic data collected from K’iche’ intracultural therapeutic and cross-cultural biomedical encounters demonstrates, the study of health care interactions involving Maya peoples in Guatemala challenges the limits of linguistic descriptions (transcripts) because these interactions did not conform interactionally or analytically to North American clinical encounters. The canonical doctor-patient interaction, featuring a single doctor and a single patient, was all but absent in therapeutic interactions among Maya groups of western Guatemala. Instead, polyphonic scene of multiple voices and pluralistic experiences (Bakhtin 1999) was populated by and composed of not only (Maya) healer-(Maya) wellness seeker intracultural therapeutic interactions but also cross-cultural (Ladino) doctor-(Maya) patient biomedical encounters.

In the ethnography of language use in health care, it has primarily been North American and European biomedical models of doctor-patient interactions that have standardized our linguistic theories and methodologies for describing and analyzing language use in clinical interactions (e.g., Davis 1989; Fisher 1986; Mishler 1984; West 1990;
Ainsworth-Vaughn 1992). If, however, we are to discover and explore what is distinct in Maya intracultural therapeutic and cross-cultural biomedical encounters and avoid flattening them out by turning them into models and interactions that mimic North American doctor-patient encounters, we must look for innovative ways to highlight their distinctiveness in our descriptions and analyses.

In the analysis of medical and therapeutic interactions that follows, every expression is approached as a kind of living thing, as “out of the cradle endlessly rocking” (Whitman 1959:181), and inseparable from human voices and experiences. For this reason, I resist applying a familiar model of monologic description to K’iche’ ways of speaking and expressing ideas about wellness, illness, and care, which would, as I have argued, have the effect of “fixing” their inevitable indeterminacy by bringing them together under a single assimilative ethnographic voice. To adopt standard sociolinguistic approaches would mean allowing the very plurality of the unmerged voices and experiences of the K’iche’ that I wish to explore to be absorbed and supplanted by a homophonic analysis, robbing them of that which we stand to learn a great deal from, their polyphonic and dialogic qualities (Bakhtin 1999). Indeed, a conventional analysis of even a quantitatively large sample of Maya ways of expressing ideas about wellness, illness and care in diverse therapeutic encounters might bear few new insights, producing instead, as Mishler (1984) and Wodak (1997) have rightly pointed out, another study of language use in health care that remains squarely within the voice and reasoning of biomedicine.

Instead, this study attempts to treat speaking, sensing, and expressing as they are encountered in life, as unfolding and unmerged dialogical movements made up of “constant [polyphonic] interaction[s] between meanings” (Bakhtin 1996:426). The potential of speaking, sensing, and expressing to condition other meanings (and be conditioned by them) lies in the indeterminacy of their fluidity or, to restate Erwin Straus’s point, in the “not yet” of these living interactions that already reaches into and out of the present. Any hope, therefore, of entering this world and understanding it through ethnography (see D. Hymes 1962; Spradley 1970; Briggs 1986; Tannen 1989) requires a description and an analysis that invokes movement, a movement that follows K’iche’ ways of speaking through multiple and diverse scenes of interaction.
A formidable challenge to attempts to analyze Maya ways of expressing ideas about wellness, illness, and care as they are encountered in the lifeworld, that is, as polyphonic scenes of simultaneous dialogism, is in the difficulty met in presenting the movements and interactions of multiple voices on the written page. Many of the taken-for-granted conventions of transcribing recorded materials in linguistic analysis have as an unstated (and largely unproblematized) aim the goal of capturing or fixing communication. Such transcription approaches, while invaluable to studies in descriptive linguistics, can inadvertently function as a kind of scientific exorcism, binding the lifeblood of movement and interaction in such a way as to rid the phenomenon of communication of its anima. Redressing this would require a dynamic analysis that reanimates the fluidity of movement and interaction in linguistic descriptions, restoring to our discussion the speaking, sensing, and expressing “who” of full-fledged subjects, placing them on equal footing with the “what” of their propositions.

It has long been noted that the conventions of any transcription method order the communicative world of recorded materials without appearing to do so, prescribing how both writer and reader think about and interact with the representations of multiple voices and experiences encountered on the page (e.g., Ochs 1979; Schieffelin 1990). What is prescribed and inscribed reflects not only the primary unit of linguistic analysis but also a theory (Edwards 1993; Mishler 1991; Jacobs-Huey 1997; Lapadat and Lindsay 1998). In this investigation, the unit of analysis is living and lived interactions and the approach, after Dell Hymes’s work (1962), is one that I term the “ethnography of polyphony.”

OVERCOMING PROBLEMS OF TRANSCRIPTION

In conventional transcription, communicative acts are made to follow a linear and evolutionary development from start to finish, from the top of the page to the bottom. Similarly, interactions between speech are represented by the order (from top to bottom) in which speakers are arranged on the page, the first to speak being represented by the first line appearing on the transcript, the second to speak by the second line, and so on. Turns of talk, interruptions, and overlaps in speech are frequently made to appear clean and tidy by introducing them as new lines of speech, often beginning at the far left margin of the page rather
than attempting to symbolically represent them where they occur relationally and temporarily in act of speaking. In such approaches, symbols are typically inserted into the text at various interactive points, their function being to indicate rather than symbolically illustrate the simultaneity and movement that constitutes interactions (e.g., Ochs 1979; Schiffrin 1994; Atkinson and Heritage 1984). Charles Briggs’s work on Warao ritual wailing in Venezuela, itself concerned with polyphony, is an important and exemplary exception, as he innovatively utilizes “musical transcriptions” (1993) rather than conventional transcripts. Another important exception is Deborah Cameron’s work in which she experiments with horizontal transcripts (2001).

The use of transcription norms can inadvertently create the illusion of communicative interactions as existing in a kind of ethereal proxemics, composed of the regular and irregular spaces that lay in the margins to the left and the right of the written word. These regular and irregular spaces on either side of what is transcribed have the effect of creating an indeterminate silence between the speech of the various interactants represented on the page. Speech in a conventional transcript, then, can tend to appear as if it were enclosed in an interactionally respected and protective bubble, influenced by but rarely appearing to interact with the speech of others. This, of course, is a privilege accorded to written speech as an object and an artifact of ethnography, one that speaking as an experience is rarely afforded in multivoiced, living, communicative interactions.

In our written dealings with communicative interactions (in transcripts) as a collection of determinable finite figures of “speech” and “expressions,” the dimensions of movement and simultaneity that are inherent in every multivoiced “inter-action” (action between interactants) tend to go underrepresented. This omission, from a phenomenological perspective on communication, inscribes a “lifeless” quality onto the recordings, recollections, and experiences of living and lived interactions. How then are we to represent the gerundial world of communication with which this research is concerned, the world in which speaking, sensing, and expressing incessantly collide and are caught up in a whirlwind of activity, interactions, reactions, and subjectivities?
THE POLYPHONIC SCORE

A theory and methodology of transcription that more closely represents the interactions of speakers in speaking rather than of speech in speech acts would begin by acknowledging the role of polyphony (multivoicedness) in communicative interactions. Here polyphony is understood as a scene of simultaneity and complex movements involving the overlap and entanglement of both the interactions of speaking and the intersubjectivities (sensing and expressing) of the interactants. In an attempt to “hitch a ride” on the movement of interaction, this study introduces K’iche’ ways of speaking and expressing not into a transcript but instead into what I call a “polyphonic score,” a symbolic illustration of a multivoiced scene communicatively composed of interreactions (see Briggs 1993; Ochs, Jacoby, and Gonzales 1994; Cameron 2001; Harvey 2003). The aim here is to describe and analyze K’iche’ ways of expressing ideas about wellness, illness, and care in their multiplicity and indeterminacy—that is, as an unfolding scene of living and lived interactions and intersubjectivities.

Introducing K’iche’ ways of speaking into a polyphonic score offers a written description that better represents the multiplicity, movement, and sociotemporal positioning of speakers and speaking in communicative interactions. Using conventional Spanish and K’iche’ orthography, each voice in a communicative scene to be analyzed is written in a separate line; multiple lines forming staves, as in music, are aligned one above another. This alignment of interactants’ voices (one above another) in the polyphonic score is primarily arbitrary and stands in opposition to the hierarchal (vertical) representation of who speaks first, second, and so on in conventional transcripts. Because time in a polyphonic score (as in a musical score) does not move down the page but rather across it, placing the communicative contributions of interactants in staves has the effect of reorganizing how we describe and analyze interactants and their actions in communication.

In a polyphonic score, no a priori transactional dominance (from the view of sociolinguistic analysis) is attributed the speaking of one interactant over that of another; analyses in which such dominance is ascribed can be seen as partial products of the observer’s paradox, that is, an effect created by the organization of language on the page.
(see Fisher and Groce 1990; Ainsworth-Vaughn 1992). That is to say, when analyzing speech in conventional transcripts in terms of representations of social power relationships, the mere structuring of the transcript (i.e., the hierarchical organization of speech according to the sequence of speakers) may inadvertently create the appearance of some speech as being socially and linguistically “over” or “above” that of others. This observation becomes particularly relevant to discussions of sociolinguistic analyses of medical discourse and the sociolinguistic power structures of institutional discourse (see Wodak 1997).

By overtly representing time in a communicative scene as unfolding across as opposed to down the page, a polyphonic score seeks to prevent interpretations of the relative social status and power of speakers that might (at least in part) be artificially based on the hierarchical representation of speech on the written page. The organization of speaking in a polyphonic score, as a representation of a communicative scene, is such that it places no unintended emphasis on one voice (i.e., on one line in a staff) over and above that of another. Significance is relational. All staves and the voices of the speakers (heard and unheard) that compose them are equally represented throughout the scene. The organization of the voices and their respective staves in a polyphonic score is arbitrary. The score is designed to represent the polyphonic composition and simultaneity of communicative interactions (speaking and expressing) as an unfolding and dynamic scene. Adopting the written form of a polyphonic score encourages a description and analysis of all speaking and expressing in communication as full valued and three-dimensional.

**SILENCE IN THE POLYPHONIC SCORE**

In keeping with this approach, all ratified (Goffman 1967, 1981) interactants present in a given communicative scene have lines in staves that are visibly represented throughout the score regardless of whether or not a given participant is speaking. This is essential because the unit of analysis is living and lived interaction, that is, the communicative actions that emerge inter- or between participants. With the risk of stating the obvious, it bears mentioning that in conventional transcription, the speech of participants alone dictates who is to be represented in a transcript. The preoccupation with speech as kind of “presence”
(being or existence) in linguistic transcription can leave the “speechless” in a communicative interaction without a voice; they are relegated to an ethnographic annotation or omitted from linguistic descriptions of an interaction altogether.

As the analyses to follow demonstrate, silence as a form of communicative action and interreaction (in addition to sociolinguistically governed behavior) can be a meaningful way of interacting communicatively (see Sansom 1983; Basso 1972). Affording the speechless lines within the staves of the polyphonic score is phenomenological recognition not only of their presence in an interaction but also of their potential as full-valued voices and full-fledged subjects to act and interreact communicatively using silence. The polyphonic score, then, opens up analytical space not only for participants’ speaking but also for their “silences” as well as a multitude of other interactions and intersubjectivities involving sensing and expressing that co-compose communication.

INTERACTION IN THE POLYPHONIC SCORE

A description and analysis of turn taking, interruptions, and overlaps in speaking are (as is demonstrated by the polyphonic score that follows) essential to our understanding K’iche’ ways of expressing ideas about wellness, illness, and care in intracultural therapeutic and cross-cultural biomedical encounters. What is needed to explore the manifold significance of turn taking, interruptions, and overlaps in speaking within diverse curative interactions is a written representation that demonstrates the qualitative as well as quantitative character of communication. In conventional transcription, interactions are primarily represented by the sequential order (and because of the medium of the transcript, the hierarchical order) in which the speech of the various speakers appears on the page.

The polyphonic score differs from the transcript in that it seeks to present the sociotemporal positioning of speaking and speakers in relation to one another rather than in relation or obedience to the structure of the written form. That is to say, because time in a polyphonic score moves across the page, the speaking that unfolds in a given set of staves is not governed by an obligation to begin by returning to the left margin. In conventional transcription, this left margin orientation is essential
because it is where movement (interactions) and development (time) occurs, making the spoken word sensible to readers as written text.

The polyphonic score frees representations of speaking from the left margin, allowing speaking and “making silence” to wander and be represented where they occur sociotemporally in relation to the other speaking and silence in a communicative scene. By presenting the interactions of all interactants as they are sociotemporally positioned in a communicative scene, the polyphonic score explicitly shows the amount of speech and amount of silence involved in turn taking and interruptions as well as overlaps in speaking. This provides both a qualitative and a quantitative illustration of the communicative composition of interactions.

Having outlined this investigation’s descriptive and analytical approach to overcoming some of the problems confronting a linguistic description and analysis of multivoiced communicative interactions, I can move on to the ethnographic and linguistic analysis of K’iche’ Maya ways of expressing ideas about wellness, illness, and care in cross-cultural biomedical and intracultural therapeutic interactions. We turn now to an examination of a cross-cultural biomedical encounter recorded at the centro de salud in the town of Nima'.
WHICH ONE OF YOU IS THE PATIENT?

Heterologues in Health Care

For many (Westerns and non-Westerns alike), biomedical “patienthood” is neither a universal nor an intuitive way of being-in-the-world but, instead, a role produced and principally acquired in biomedical clinical interactions

MAYA MULTIVOICED ILLNESS NARRATIVES IN BIOMEDICAL ENCOUNTERS

The first clinical encounter to be examined is a cross-cultural biomedical interaction between a Ladino Spanish-speaking doctor and Maya K’iche’-speaking wellness seekers. The consultation occurred at a centro de salud, a government-funded and staffed health care outpost, located in the township center of Nima’. The audio recordings of the clinical consultation were jointly made by the consultation participants: attending physician, wellness seeker, and her two companions. At the time of the investigation, the centro de salud of Nima’ was staffed by a full-time general practitioner, one certified nurse, two auxiliary nurses, a K’iche’ cultural and linguistic translator/health promoter, a public health inspector, a clinic receptionist, and a maintenance person. Ethnically, with the exception of the K’iche’ translator/health promoter, the centro de salud staff all self-identified as Ladino (Hispanophone), a point that has considerable sociolinguistic significance for the analysis (see Warren 1978; Hsieh, Ju, and Kong 2009).

Visitors to the centro de salud both from within the municipality of Nima’ and its outlying aldeas (villages) are primarily K’iche’ Maya women and their children (around 90 percent of all visitors). The clinic is open Monday through Friday, and each weekday morning wellness seekers arrive early, forming a seated line on a concrete embankment...
that runs along the front of the building. The bulk of the consultations on any given day occur in the morning; consultations after 12 p.m. tend to be for medical emergencies and follow-up visits. Visitors try to arrive early because being seated nearest to the clinic door when it opens means that they will be among the first to receive medical attention.

Clinic guidelines loosely set the number of available morning consultations (scheduled for between 8:00 a.m. and 12:00 p.m.) at twenty patients, though more or less visitors may seek consultations on a given day, and the number that show up on a given day tends to correlate with the town’s market $k'ayib'al$ days. In Nima’ Tuesdays and Fridays of every
week are market days, and thus these are correspondingly slow days at the clinic, at times leaving the medical staff to attend to only a handful of patients. The primary reason for this is that the majority of the Maya women who would typically attend the centro de salud on these days postpone their visits to the clinic, going instead down to the edge of the village where they can be found selling their goods at the market. In a town where a large portion of the typical family’s income is generated from the production and sale of farm goods, the effect of market days on clinic attendance is significant (see Little 2003). K’ayib’al mobilizes the farming community of Nima’ because it brings to town shoppers from outlying areas and neighboring villages, presenting local sellers with economic opportunities that are not to be missed.

It can be said that the K’iche’ of Nima’ organize their visits to the centro de salud around their work schedule, the exception being when emergencies arise. It bears mention here, however, that their work schedule is only one significant decision-making factor when they are considering pursuing biomedical attention at the centro de salud. K’iche’ decisions to seek indigenous forms of Maya therapeutic care are governed by other cultural factors, discussed in chapter 5 on intracultural therapeutic care (see Adams 1952; Wisdom 1952; Adams and Rubel 1967; Douglas 1969; Cosminsky 1972; Fabrega and Silver 1973; Orellana 1987; Jordan 1993; Berlin and Berlin 1996; Huber and Sandstrom 2001; Hinojosa 2002).

POLYPHONY IN K’ICHE’ CLINICAL ENCOUNTERS

We now turn to an analysis of a segment of a K’iche’ cross-cultural biomedical encounter recorded at the centro de salud as well as to a description of the notations used in the polyphonic score. The complete score of the entire encounter (written in K’iche’ and Spanish) can be found in appendix A. The English translation of the encounter is shown in scores located in appendix B. The following are abbreviations for the participants: WS = wellness seeker; B = baby (the child of the wellness seeker); C1 = first companion of wellness seeker; C2 = second companion of wellness seeker; and D = doctor. Note that the researcher is not given a line in the staves of the score, as only the participants listed were physically present during the recording of the consultation.
Figure 1

Polyphonic score

Bar 1.

WS: Chich'a k'u chi re wach ri k'ax.
B: Mir e,
C1: Jas wach ak'ax?
C2: dice gue se vino otra vez. A veces se hinca su estomago en la noche, en el dia.
D: Muy bien Isabel, ¿cúntame en qué te puedo servir? ¿Que te está pasando?

Bar 2.

WS: Arese, re kinb'ij xinpe k'u wa che ri jun viaje ri in. Je, kub'an ch'u kut
B: Las wash ak'ax?
C1: doctor, no puedo decir. Ji, ji.
C2: dice que vino a ... regló aquel, la vez pasado dijo ella—es que la enfermedad que tiene.
D: ¿Eh, en la vez pasada qué

Bar 3.

WS: le summul ta viaje chik.
B: doctor no puedo decir. Ji, si.
C1: dice que se vino otra vez. A veces se hinca su estomago en la noche, en el dia.
C2: dice gue se vino otra vez. A veces se hinca su estomago en la noche, en el dia.
D: Chich'a k'u chi re wach ri k'ax.

Bar 4.
C1: Huh... jas... jas wach xuyo'o?
C2: Le dij eron
D: tratamiento, qué, qué pastillas o qué fue lo que le dimos aqui? ¿Que fue lo qué le dije que tenia?

Bar 6.
WS: es úlcera o...
B: ...
C1: Sí.
C2: es... es su enfermedad pero...
D: ¿El tratamiento que le dimos son las cápsulas blancas? Que tomo veinte-
C1: ocho días? ¿Sí? ¿Hubo alivio con estas cápsulas? ¿Y cuánto tiempo tiene que ya dejó de tomar las cápsulas? ¿Ya no está tomando las cápsulas cuanto tiempo hace?

Bar 7.
D: ¿El tratamiento que le dimos son las cápsulas blancas? Que tomar veinte-
C1: ocho días? ¿Sí? ¿Hubo alivio con estas cápsulas? ¿Y cuánto tiempo tiene que ya dejó de tomar las cápsulas? ¿Ya no está tomando las cápsulas cuanto tiempo hace?

Bar 8.
D: ¿El tratamiento que le dimos son las cápsulas blancas? Que tomar veinte-
C1: ocho días? ¿Sí? ¿Hubo alivio con estas cápsulas? ¿Y cuánto tiempo tiene que ya dejó de tomar las cápsulas? ¿Ya no está tomando las cápsulas cuanto tiempo hace?
Bar 1.

WS: You all, tell of the essence of the pain.

B: Very well, Isabel, tell me in what way can I serve you? What is happening with you?

C1: She says that it has come again. Sometimes it [the pain / illness] makes her stomach swell at night and in the day.

C2: What is the nature of your pain?

D: Very well. Isabel, tell me in what way can I serve you? What is happening with your pain?

Bar 2.

WS: I say, I arrived here once before. Yes, well, once more it [pain / illness] has made another trip.

B: She says that she came to improve it [pain / illness]. The time before, she said—It's that the illness she has.

C1: She says that she came to improve it [pain / illness], the time before, she said—It's that the illness she has.

C2: What is the nature of your pain?

D: Very well. Isabel, tell me in what way can I serve you? What is happening with your pain?

Bar 3.

WS: She says that she came to improve it [pain / illness], the time before, she said—It's that the illness she has.

B: She says that the time came to improve it [pain / illness], the time before, she said—It's that the illness she has.

C1: She says that it has come again. Sometimes it [the pain / illness] makes her stomach swell at night and in the day.

C2: What is the nature of your pain?

D: Very well. Isabel, tell me in what way can I serve you? What is happening with your pain?
Bar 8.
Did she stop taking the capsules? Now she's not taking the capsules for how long?

Bar 7.
The treatment that we gave you were the white capsules? It's her illness but... Then...

Bar 6.
What, what was it that we gave you here? What was it that I said you had?

Bar 5.
Yes, there was. It's an ulcer or...

Bar 4.
And how much time has it been now?

Bar 3.
The y told her...

Bar 2.
What was the essence of what he gave you?

Bar 1.
The treatment, what, what pills or what was it that we gave you here? What was it that I said you had?
In the analysis that follows, a numbered bar (e.g., bar 1, bar 2, etc.) is used when referring to a particular section of the polyphonic score. Each numbered staff refers to the speaking and interacting of all five participants—in this case a collection of five lines. This form of notation attempts to unmoor the discussion from the decontextualizing affects of sentence-by-sentence analyses that are sometimes associated with the otherwise innovative notation practices utilized in conversation analysis (see Moerman 1988). Instead, my approach seeks to consistently implicate the wider sociolinguistic scene in order to facilitate a description and analysis of “inter-action” (i.e., the communicative acts produced and emerging “inter” or between the various interactants).

Similarly, I have not numbered the lines, as such numbering can inadvertently contribute to a description and an analysis of speaking as neatly linear and perhaps sequentially overdetermined. The numbering of lines also tends to create a system of reference that allows for an artificial separation (or dichotomy) between speaking and speakers (i.e., between the “who” and the “what”). That is to say, describing the verbal contributions of interactants in communication as “speech” entails a subtle linguistic transformation of the act of speaking into a concrete thing, a transformation that separates the actor, the speaker, from the act, speaking. Therefore, referring to the speech, for example, in line number 12 is not the same as referring to the speaker of that line or vice versa. The former privileges an object of science and the latter the subject of anthropology. In my analysis, lines of a staff are only referred to in context; that is to say, speakers are inseparable from speaking, and the two are inseparable from the scene or context of the interaction. A line in a staff, therefore, is referred to as, for example, WS:1. This scene-centered notation indicates that the speaking being discussed is that of the wellness seeker (WS) and that it occurs within the larger sociolinguistic context of an interaction represented in bar 1, hence, the notation WS:1.

The score shows a Maya wellness seeker (WS) and her baby (B) accompanied in the biomedical encounter by two female companions (C1 and C2). The social composition of clinical encounters is noteworthy, as it provides insight into larger community-wide social and interactional practices characterized by the preference of K’iche’ Maya of Nima’, which they enunciate in just about every expression of human endeavor, for what might be called “living life accompanied” (see Harvey
Indeed, what most stood out to me early in my fieldwork experience was how nearly everything done in the living around me seemed to be suddenly either *wuk'* (with me), *awuk'* (with you), *ruk'* (with her, him, or it), *quk'* (with us), *iwuk'* (with you all), or *kuk'* (with them) (see Turner 1980, 1994). Among the Maya peoples with whom I lived and worked, very little of everyday life that could be experienced with others was left to be lived alone. At the *centro de salud*, the fact that the physician had placed within his office not a single chair for an individual patient but rather a wooden bench that could seat three or four adults facing his desk indicated his acute cultural awareness of this “accompanied” social practice (for an excellent example of a similar adaptive organization of clinical space in Guatemala, see de Cap 1993 and Tujal 1993).

**NO CORN, NO FOOD, NO FRIENDS (LESSONS IN CULTURAL COMPETENCE)**

Although I did not realize it at the time, a key that would unlock several doors behind which stood answers to many of my questions concerning the nature of Maya social relations (within and outside of curative interactions) was offered to me midway through my fieldwork. A brief description of this experience bears mentioning here, as I believe it offers another vantage point on the experiential scene where K’iche’ ways of expressing ideas about wellness, illness, and care unfolds. A favorite pastime of those closest to me in Nima’ was teaching me the K’iche’ language, a task made amusing by their habit of giving me pop quizzes in public places.

On one such occasion, Si’s, an *ajq’ij*, asked me “*Jas ub’ixik amigo pa ch’ab’al?”* (“How do you say *friend* in K’iche’?”). After giving it some thought I conceded, “*Ma wetam taj*” (“I don’t know”). With a smile forming Si’s replied, “*K’o taj!”* (“There are none!”), explaining that in K’iche’, there are no friends, “*xaq xuwi rachil*” (“only your companion”). A cognitive linguistic study of K’iche’ in Chichicastenango, Guatemala, seemingly unrelated to the issue of accompanied social relations, makes a similar observation of companions, pointing out that foods among Maya peoples are also thought of as having their necessary companions (Henne 1981).

The word for “food” in many Maya languages is *wa’*, and as one story goes, after inviting a group of Maya friends to fancy dinner in
an upscale restaurant, a foreign host was surprised, after all the food had arrived, to hear his Maya companions’ innocently yet insultingly ask, “Jawi kowi le wa?” (“Where is the food?”). With a table full of food, why would anyone ask such a thing? Emily Post would be horrified! The answer is a simple one: only corn can be called wa’; only corn is food, and everything else, however various and delectable, are the companions (rikil) of food, mere compliments to corn (Henne 1981). But among the Maya peoples with whom I worked, it wasn’t just food that should be accompanied. The importance of the concept of “accompanied living” to an understanding of the sociolinguistics of K’iche’ communicative and comportment practices became increasing salient in my analyses of medical consultations.

**COMPANIONS AND MEDICAL MISUNDERSTANDINGS**

Returning now to the score, we see that in the first bar the physician initiates the medical inquiry, as is a common communicative practice in biomedical encounters (see Mishler 1984; Fisher and Groce 1990; Ainsworth-Vaughn 1992; Wodak 1997; Sandhu et al. 2009). This, as the analysis of other intracultural interactions suggests, differs from how Maya therapeutic encounters are initiated. The wellness seeker, who the medical professionals refer to by her first name, Isabel, does not respond to the doctor’s questions expressed in Spanish (“Cuéntame en qué te puedo servir? Que te está pasando?” [D:1] [“In what way can I serve you? What is happening with you?”]). Instead, Isabel says to her companions in K’iche’, “Chich’a k’u chi re wach ri k’ax” (WS:1) (“You all, tell of the essence of the pain”). The first companion responds to the wellness seeker’s request by saying to the physician, “Mire, doctor, no puedo decir. Ji, ji” (C1:2) (“Look doctor, I am not able to say. Hee, hee”). Though not immediately discernible in written form, C1:2 is an example of cross-linguistic miscommunication, a phenomena of which the participants in bar 1 were well aware. To make the subtlety of the first companion’s saying “No puedo decir” (“I am not able to say”) more noticeable as miscommunication, I suggest approaching C1:2 as a kind of inadvertent metalinguistic commentary.

The follow-up ethnographic transcription and annotation (see Schieffelin 1990) of this encounter revealed (as the doctor had understood it) that what the first companion in C1:2 of the score had intended
to say to the physician was “Mire, doctor, ella no puede decir” (“Look doctor, she [the patient] is not able to say”). In misspeaking and saying to the doctor “I am not able to say” the message that the first companion is trying to communicate is inadvertently made more clearly here than it would have been had she spoken correctly and said, “She is not able to say.”

What is expressed in the first companion’s misspoken statement “I am not able to say” is the difficulty that both she and the wellness seeker experience when trying to communicate in Spanish. Therefore, in an unlikely way, misspeaking and saying “I am not able to say” shows precisely what she is trying to say about the wellness seeker in addition to demonstrating her difficulty with Spanish. The result of this misspeaking says to the doctor that “we are not able to say.”

Not all miscommunication, then, necessarily results in misunderstanding (see Sachs 1989). When marked and semantically functioning (albeit inadvertently) as a form of metacommunication (i.e., as language that comments on language and its user) misspeaking can “show” (indexically) through the act of speaking what well-spoken words can only “say” (referentially). Although at first glance an alternate explanation for “I am not able to say” might appear to be that the first companion is merely expressing her unfamiliarity with the illness, her uncomfortable laughter after her statement points to her recognition of the peculiarity of her utterance. Further analysis of this and like encounters shows that Maya companions in curative encounters are intimately involved in the illness experience, a phenomenon that not only enunciates the *achi’l* (companioned) nature of Maya social relations but also indirectly questions Western cultural presuppositions about the nature of illness experience as something “owned” and lived by individuals (see Janzen 1978; Ohnuki-Tierney 1984; Harvey 2008b).

**CO-COMPOSING ILLNESS NARRATIVES**

I turn now to the issue of illness narratives—the retelling and social sharing of illness experiences by matching verbal sequences of clauses to a sequence of events (Labov 1972; D. Tedlock 1983; Kleinman 1988; Mattingly 2002)—and explore their sociolinguistic role in curative interactions. I examine the composition of *K’iche’* illness narratives in a cross-cultural biomedical consultation, focusing on what
conversational analysts have called turns of talk, adjacency pairs, and sequences (Schegloff and Sacks 1973; Sacks et al. 1974).10 Beginning with an examination of bars 1–2, we see that while the first companion did not promptly, as the wellness seeker had requested “tell of the essence of the pain” (WS:1), the second companion did follow up on this request, asking the wellness seeker in K’iche’ “Jas wach ak’ax?” (C2:2) (“What is the nature of your pain?”). The wellness seeker answers her second companion but provides little detail about the pain, only saying, “Arese, re kinb’ij xinpe k’u wa che ri jun viaje ri in. Je, kub’an ch’u kut le junmul ta viaje chik” (WS:2–3) (“I say, I arrived here once before. Yes, well, once more it [i.e., the pain/illness] has made another trip”).

Notably, it is the first companion and not the second who relays to the doctor in Spanish what the wellness seeker has said in K’iche’, saying, “Dice que vino a . . . regló aquel, la vez pasado dijo ella—es que la enfermedad que tiene, dice que se vino otra vez” (C1:3–4) (“She says that she came to improve it [the pain/illness], the time before, she said”). Here, we begin to see within this small interplay of voices (bar 2 and bar 3) the telling of a K’iche’ illness narrative beginning to take shape and some of the interactions of speaking and expressing involved therein. K’iche’ illness narratives, as it will become increasingly clear, are not homophonic accounts told in a single authoritative voice of an individual patient who “owns” the illness or the ensuing experience (see Basil 1983; Briggs 1986). K’iche’ illness narratives are polyphonic (Bakhtin 1999), containing the interactions and intersubjectivities of multiple voices and pluralistic experiences.11 These illness narratives reveal a participatory structure that suggests “a delicate device for cooperation, for showing that parties are of a single mind, for allowing them to become a single social person by together fabricating an utterance” (Moerman 1988:27).12

A closer look at the interactions in bars 2 and 3—where the wellness seeker says, “I say, I arrived here once before. Yes, well, once more it [i.e., the pain/illness] has made another trip” in response to second companion’s question “What is the nature of your pain?”—reveals that the wellness seeker’s account does not include all that her first companion subsequently relays to the doctor about the illness in Spanish (C1:3–4) (see Linde 1986; Diaz-Duque 1988; Davidson 2001).

Notice that in addition to telling the doctor that the wellness seeker “says that she came to improve it [the pain/illness], the time before, she
said,” the first companion adds something more to the illness account saying, “Sometimes it [the pain/illness] makes her stomach swell at night and in the day” (C1:4). Here we see that K’iche’ illness narratives utilize the “appended accounts” (Fisher and Groce 1990) of multiple voices and pluralistic experiences in their sociolinguistic formation. They are co-composed of “inter-actions,” literally the actions and meanings produced between the various voices and experiences that are co-opted in the social retelling and sharing of illness experiences (see Frake 1961; Mishler 1997). Some conversation analysts have labeled this kind of cooperative participatory structure as “talking as a team” (see Moerman 1988).13

But illness narratives, as lived and “living” interactions, cannot be separated from their narrators or from the scenes where they unfold; doing so for the sake of an analysis would deprive them of their subjects (the narrators) and rid them of their scenes (living contexts). In addition to being interactions, the multiple voices and experiences involved in K’iche’ polyphonic illness narratives make them kinds of intersubjectivities, irreducible to depersonalized objects of inquiry, just in the same way that the experiences of wellness seekers are irreducible to biomedical diseases. K’iche’ illness narratives occur interactionally between speaking and expressing full-fledged subjects, who are *achi’lab’,* both in the composition of narrative and in the experience of illness. The analyses here of Maya intracultural therapeutic encounters demonstrate that the explicit interactions of voices observed in the formation of illness narratives in this encounter are neither atypical nor the product of the Maya wellness seeker’s lack of “communicative competence” (D. Hymes 1962, 1974) in Spanish.14 Rather, co-composed narratives are culturally appropriate K’iche’ ways of speaking about wellness, illness, and care.

Before discussing what more can be learned from the score about communicative interactions between K’iche’ wellness seekers and their companions in medical encounters, I turn to the communicative practices of the physician and some characteristics of cross-cultural physician-patient interactions in Guatemala. Although the score only shows the physician interacting and conducting the medical interview in Spanish, my analysis of the medical encounter is not limited to the immediate context of the clinic nor is it confined to the contents of the score. Following rather than fixing the voices of wellness seekers and of
health care practitioners leads back to ethnography and the sociocultural setting of clinical interactions in Nima’.

COMMUNICATIVE COMPETENCE AND MEDICAL TRANSLATORS

The physician at the centro de salud in Nima’ was considered by locals to be (and self-identified as) Ladino, a non-Maya and Spanish-speaking Guatemalan. This social role made his interactions (clinical and otherwise) with the K’iche’ townspeople and made their interactions with him cross-cultural in nature. At the time of the investigation, Dr. Francisco had worked at the centro de salud for fifteen years. During this period he had participated in many community-wide activities and celebrations with the townspeople and was, on the whole, well regarded by them. As I came to know Dr. Francisco personally I discovered that contrary to my initial impression, he was not monolingual in a straightforward sense.

He had learned a considerable amount of K’iche’ during his time spent working in and interacting with Nima’ residents. In fact, on his desk in the consultation room, he kept a notebook that he had compiled of K’iche’ health and illness terminologies and local sayings. Although Dr. Francisco told me that he did not feel comfortable conducting medical interviews in K’iche’, he demonstrated in several consultations a good understanding of the contents of what was said in K’iche’ between Maya wellness seekers on topics of health and illness. For example, during a consultation he would insert information into his medical inquiries that was directly relevant and directed toward addressing nontranslated concerns expressed in K’iche’ between wellness seekers and their companions. In turning now to the specific ethnographic scene of the score, I note a rather interesting occurrence. Despite the wellness seeker expressing her discomfort with communicating in Spanish, saying, “You all, tell of the essence of the pain,” the physician neither requests nor receives the assistance of Mario, the clinic’s fulltime K’iche’ translator and health promoter. Medical professionals at the centro de salud typically made the determination regarding whether to use a translator in physician-patient consultations long before monolingual patients ever reached the primary consultation.

Before receiving a medical consultation with the physician, each visitor to the centro de salud waits in line to check in with the clinic’s
receptionist, who records their names and gives each of them a piece of paper with a number that is called when it is their turn to receive medical attention. If considerable communicative difficulty is evident at the check-in stage of a clinical visit, it could identify a particular wellness seeker and their companions as being in need of the assistance of the cultural and linguistic translator (see Davidson 2001).

During my time at the clinic I did not observe communication difficulties that were discovered at the check-in stage of a medical visit. This was likely due to the fact that friends and family members almost always accompanied wellness seekers to the centro de salud, cooperatively speaking on their behalf, sometimes throughout a clinical encounter. In fact, it was frequently the case that the family and companions checked in with the clinic’s receptionist and not the wellness seekers themselves. This is a social practice that makes it difficult to identify potential communication difficulties on the part of the wellness seeker at the initial stage of clinical interaction.

After wellness seekers are checked in with the receptionist, but before they receive their consultations with the physician, they are evaluated by the centro de salud’s certified or auxiliary nurses in what are called preconsultations. Here, nurses check vaccination cards, take brief medical histories of wellness seekers, record their height and weight, and check their blood pressure and temperature. The preconsultation is the last stop before the primary consultation, and vital health information derived from it is passed on to the physician.

If communication problems are identified at this stage, the nurses will ask for the translator’s assistance and subsequently ask that he accompany the wellness seeker and her/his companion(s) into the primary consultation with the physician. In the preconsultation that corresponds to the primary consultation represented in the score, no such communicative problems where identified and therefore no recommendation for the translator was made. This is perhaps attributable, again, to the family and companions of the wellness seeker, who cooperatively do most of the speaking and the bulk of the responding to questions about the illness experience.

An ethnography of the scene surrounding the clinical interactions represented in the score helps explain why, despite the wellness seeker’s discomfort with Spanish, the translator was not present when the
physician received the wellness seeker and her companions. At the
time of my study, the presence and use of K’iche’ by wellness seekers and
their companions in the clinic did not (in the view of practitioners) have
the potential to cause communication problems. Collaboration between
wellness seekers and their companions is not simply tolerated by the
practitioners but expected. Only when this collaboration fails to pro-
duce the expected communication between practitioners and wellness
seekers is the presence and involvement of the cultural and linguistic
translator sought. For this reason, though there is considerable use of
K’iche’ in the primary consultation analyzed here, the assistance of the
cultural and linguistic translator is neither recommended nor requested.

COMPLICATIONS OF THE MEDICAL INTERVIEW

Despite a clinical environment that encourages first-language collabo-
ration between the K’iche’ wellness seeker and her companions, fur-
ther analysis of the above encounter reveals (in bars 4–5) complications
in clinical communication arising nonetheless. Returning now to the
analysis of the score, I examine the physician’s communicative practices
and interactions with the wellness seeker and her companions, focusing
on how they contribute to complications in communication. I begin by
examining the physician’s use of multiple questions successively, a com-
unicative practice consistent with the biomedical interview structure
(see Shuy 1974) in general. In bars 4–5 the physician asks the wellness
seeker and her companions a series of four questions in rapid succe-
sion, not pausing or allowing for a response to any one question until
after his final question has been uttered. For the purpose of observation
and analysis I separate the physician’s successive questions into indi-
vidual interrogatives. They are as follows: “¿Eh, en la vez pasada qué
tratamiento?” (D:4–5) (“Uh, on the last time what treatment?”); “¿qué,
qué pastillas?” (D:5) (“what, what pills?”); “¿o qué fue lo que le dimos
aquí” (D:5) (“what was it that we gave you here?”); and “¿Qué fue lo qué
le dije que tenia?” (D:5) (“What was it that I said you had?”).

Midway through the physician’s final question, “What was it that I
said you had?” the first companion begins relaying the physician’s third
question to the wellness seeker in K’iche’. Here, the first companion asks
the wellness seeker, “Huh . . . jas . . . jas wach xuyo’o?” (C1:5) (“Uh, what
. . . what . . . was the essence of what he gave you?”), and for a moment
WS: Uh . . . what . . . was the essence of what he gave you?

B: They told her.

C1: What . . . what . . . was the essence of what he gave you?

C2: They told her.

D: Treatment, what, what pills or what was it that we gave you here? What was it that I said you had?

WS: Bar 5.

D: Treatment, what, what pills or what was it that we gave you here? What was it that I said you had?

C2: They told her.

C1: What . . . what . . . was the essence of what he gave you?

B: They told her.

C1: Uh . . . what . . . was the essence of what he gave you?

C2: They told her.

D: Treatment, what, what pills or what was it that we gave you here? What was it that I said you had?

WS: Bar 5.

D: Treatment, what, what pills or what was it that we gave you here? What was it that I said you had?

C2: They told her.

C1: What . . . what . . . was the essence of what he gave you?

B: They told her.

C1: Uh . . . what . . . was the essence of what he gave you?

C2: They told her.

D: Treatment, what, what pills or what was it that we gave you here? What was it that I said you had?

WS: Bar 5.
there is an overlap in the speaking of the physician with that of the first companion (D:5 and C1:5). This overlap or “the simultaneous talk of more than one speaker” (Moerman 1988:19) creates a communicative copresence where neither physician nor the first companion yields the floor to the other (see the gray/shaded area in the bar 5 in figure 5) (see Sacks et al. 1974).

As these bars demonstrate, the doctor completes his question without pausing, as the first companion traverses the question proffering a K’iche’ translation of the physician’s third question. Notably, the physician does not stop speaking, because his question is traversed rather than bisected or cut off. The effect is that their speaking (both that of the physician and the first companion) “blankets” or covers that of the other, but neither speaker is cut off or interrupted. That neither participant yields the floor (i.e., initiates a repair) or is cut off despite the traversing might be attributable to the copresence of two codes (Spanish and K’iche’). This phenomenon is not unlike the overlapping speech observable in so-called simultaneous translations. It is also noteworthy that conversation analysis has found orderliness in overlaps, suggesting that they most frequently occur at “speakership transition points” (Moerman 1988:19) or areas where turns of talk are negotiated and anticipated (Sacks et al. 1974).

Throughout the clinical interaction the first companion consistently acts as translator, but because of the overlap in the physician’s and her speaking in bar 5, the physician’s final question (“What was it that I said you had?”) is not relayed to the wellness seeker in K’iche’. It is also important to note that the effect of successive questioning in the medical interview structure is not merely that the physician’s fourth question is not translated. As the polyphonic score shows, neither the first question (“Uh, on the last time what treatment”) nor the second (“what, what pills”) are relayed in K’iche’. Also interesting and perhaps related to successive questioning is a kind of communicative conditioning, observable in the way that first companion relays the third question, reproducing in K’iche’ some of the physician’s hesitations and even some of his false starts, saying to the wellness seeker, “Uh, what . . . what . . . was the essence of what he gave you?”
MAYA INTERACTIONAL STYLES (CO-COMPOSED MEDICAL HISTORIES)

Amid the complexity of this loquacious field of clinical interaction, with its multiple voices and the pluralistic experiences of the physician, wellness seeker, her companions, and her child, arises communicative collaboration. Following the dialogic movements of speaking and expressing across the interactions represented in bars 4–7 shows the emergence of a complex coauthoring of meanings and understandings between the wellness seeker and her companions that while unscripted seems at times almost symphonic in its simultaneity. As the physician’s third question is being relayed to the wellness seeker in K’iche’ by the first companion, the second companion begins responding to the physician in Spanish saying, “Le dijeron es . . .” (C2:5–6) “They told her it’s . . .,” at which point the wellness seeker interjects, saying in Spanish, “Es úlcera o . . .” (WS:6) (“It’s an ulcer or . . .”). Almost without hesitation the second companion completes the wellness seeker’s response to the physician, incorporating the wellness seeker’s interjection contiguously into her own response so as to make their combined response sound as if it were a single utterance, saying, “They told her it’s . . .,” “It’s an ulcer or . . .,” “. . . it’s her illness but . . .” Here, two distinct voices sound in a harmonic series, creating a third, a kind of musical overtone from the two (C2:5 and WS:6), coauthoring a new meaning and understanding in the illness narrative.

It bears mention that the collaborative response of the second companion and the wellness seeker is not an answer to the physician’s third question translated by the first companion as, “Uh, what . . . what was the essence of what he gave you?” Rather, they are responding to his fourth question (“What was it that I said you had?”), which, despite being phrased in Spanish and overlapped by the first companion’s translation is not lost. The survival of the physician’s fourth question amid these would-be communicative obstacles is attributable not merely to the fact that it is the last question in a string of four questions but also to the fact that “What was it that I said you had?” is traversed and not bisected, overlapped but not cut off by the first companion’s work of translation. The second achi’il’s beginning the illness narrative by saying “They told her,” which is completed by the wellness seeker’s response that “it’s an ulcer or . . .,” demonstrates intimacy with the illness experience and contributes freely to the composition of the illness narrative.
Figure 6
Polyphonic score

Bar 7.


B: 

C1: Sí. En tonces . . .

C2: Sí. 

D: ocho días? ¿Sí? ¿Hubo alivio con estas cápsulas? ¿Y cuánto tiempo tiene ya que va?

WS: Y es. Yes, there was.

B: 

C1: Yes. So then . . .

C2: Yes. Yes. Yes.

D: eight days? Yes? Was there alleviation with those capsules? And how much time has it been now?
The participatory structure of communicative interactions is not, however, limited to the complex interplay of speakers in speaking. The silent interreactive contributions of *expressing* to the participatory structure of communication must also be considered, despite the problem of their lubricity. The polyphonic score offers the unique opportunity for an analysis of participatory structure that includes both the interactions between the various speakers and speaking as well as the interactions between their speaking and their “communicative silences” (Bruneau 1973).

An examination of bar 7 shows in ways that a conventional transcript could not communicative clusters of verbal participation involving the movement and interplay of meaning and understanding between the multiple voices and experiences brought together in the biomedical encounter. To state, for the purpose of analysis, what is so easily revealed in the communicative cluster in bar 7 requires a kind of descriptive double-jointedness, flexible enough so as to not make disjoined the harmonic flow of interactions shown in bar 7.

Here, the harmonic sounding of multiple voices is a dialogic emergence, played in human chords across a field of communicative interaction. The score registers graphically the movements of these soundings: “Sí” (“Yes”), “Sí” (“Yes”), “Sí” (“Yes”), “¿Sí?” (“Yes?”), “Sí” (“Yes”) (C1:7, C2:7, D:7, C2:7), tracing the curves and paths of living interactions in much the same way that a cardiograph displays movements of the heart. In displaying clusters, the score illustrates the participatory structure of interactions and their distribution between participants.

The wellness seeker here is not speaking in the communicative cluster. Indeed, the blank spaces in her lines that are distributed throughout the twenty-six staves that compose the score show that the wellness seeker is frequently silent. This does not, however, mean that she is not involved in the communicative silences, that is to say, in interacting communicatively without speaking (see Braithwaite 1990). As further analysis of this score in next chapter demonstrates, being silent as a way of expressing “moves” and emerges in a communicative interaction in much the same way as speaking does. Following the meanings of these movements can reveal how “silence may be as variously shaded as speech” (Wharton 1996).
If we had a keen vision and feeling of all ordinary human life, it would be like hearing the grass grow and the squirrel's heart beat, and we should die of that roar which lies on the other side of silence.


**MEANING IN MAKING SILENCE**

With the initial application of the polyphonic approach to the cross-cultural consultation in Nima’ discussed in the previous chapter, we have begun to explore what the reorganization of representations of speakers and speaking on the page can reveal about communicative interactions. This chapter carries the methodology further in our examination of the Nima’ consultation by exploring some of the forms of communicative action that lay on the other side of speaking, the overshadowed whispers and the silence of the collogue. Because speech in discourse and conversation analysis has been overwhelmingly equated with “presence,” silences like those expressed by the wellness seeker in the *centro de salud* consultation have all too often been overlooked, depicted as “absence,” and explained away as disempowerment (for some notable exceptions, see Sansom 1983; Nwoye 1985; Philips 1985; Saville-Troike 1985). But the silences of full-fledged subjects must be spared the fate of “absence” and disempowerment if we are to understand them as full valued rather than as impoverished ways of interacting communica-tively. The polyphonic score put forth in this study provides the graphic representation needed to observe and analyze what cannot be heard, providing a space for silence to emerge as “presence” on the other side of speaking.

Following the interplay of interactants and interactions throughout the bars of the polyphonic score reveals the “presence” and “absence”
of silence, ebbing and flowing between speakers and speaking, filling and draining the communicative field. In this study silence and speaking are treated as interdependent communicative actions (see Jaworski 1993). The simultaneity of their counterpositioning produces meaning: the one owes its existence to the other, and each is only half of what makes communicative interaction possible. In communicative interactions, silence does not just happen or exist ontologically “out there” on its own; silence is made, its movement among speakers creates the meanings between their speaking.

There is an entire language that has been developed by the field of linguistics to describe and analyze speech in communicative interactions, but the same cannot be said of silence as a communicative act (see Samarin 1965; Basso 1972; Bruneau 1973; Tannen and Saville-Troike 1985; Braithwaite 1990; Jaworski 1993; Gudykundst 2005). While we can and do speak of the momentary silence of pauses and hesitations (see Schegloff 1972; Chafe 1985) and the sociolinguistics of situational silence (Walker 1985), communicative interactions are overwhelmingly described from the view of speech. Therefore, in discourse analysis it is speech that interrupts, that takes turns, that manages the floor, that overlaps, that repairs, that presequences, that opens, that closes, and so forth (e.g., Schegloff 1968; Sacks et al. 1974; Levinson 1983).

**SILENCE AS “PRESENCE” AND DOING**

When silence is considered as a form of doing, as in the English transitive verb “to silence,” it is generally used to describe an agent (a subject) that does the “silencing” to a patient (a direct object). This is the world that our language and culture encodes and that conventional transcription and analysis reproduces; that is, a world where speech is “presence” and “doing” and silence is “absence” and “not doing” (see Mentore 2004, 2005). We do not, then, frequently think of the “speechless” in communicative interactions as “making silence” because they are often absent from our transcriptions altogether (or at best relegated to an ethnographic description or annotation). And while it may be the case that with a transcript in hand we do not have to see precisely what is transpiring in an interaction to make sense of it, the sense that we make of it is necessarily influenced by who and what we see represented (or included) on the page.
Now that we have a polyphonic score that allows us to “see” the inaudible making of silence by interactants as a kind of “presence,” how might we begin to categorize and analyze the relationships between silence and speaking in communication? Indeed, the thought of “seeing” silence in the making of interactions may seem foreign or even fanciful at first glance but I argue that it is neither (see D. Tedlock 1987; Pitarch 2010). In considering this issue, I am reminded of a rather stereotypical exchange between U.S. truck drivers that I heard over the radio while traveling one summer. One of the drivers announced, “Wow! I just heard a beautiful woman.” Moments later, another driver chimed in, asking him, “How can you hear a beautiful woman?” “You listen!” quipped the first driver. As silly as this may sound, “seeing” silence, like hearing beauty, requires an entanglement of the senses, calls for having synaesthetic eyes to hear and ears to see, because the sensing being experienced is not identical with what stimulates it. In a similar way the blank spaces along the staves that compose the polyphonic score must be “seen” in order to be “heard” as what I call the meaningful making of communicative silences. Neither random nor arbitrary, they are the silent (yet structured) contributions of interactants to the composition of communicative interaction. Speaking and making silence are interdependent parts of communicative interaction. As Pierre Bourdieu has observed,

> Because the subjective necessity and self-evidence of the commonsense world are validated by the objective consensus on the sense of the world, what is essential goes without saying because it comes without saying: the tradition is silent, not least in itself as a tradition. (1997:167)

**DISCOURSE ROLES OF SILENCE**

By taking seriously the proposition that making silence is half of the action needed to make communicative interactions possible, we can begin laying the foundation for an anthropological linguistic discussion of the “makings” and movements of silence among speakers and between their speaking. When examined systematically, the contributions of communicative silences to the participatory structure and configuration of communicative interaction may be preliminarily described and analyzed in the following ways. The making of silence by “ratified”
interactants can 1) sustain the floor for other interactants involved in speaking; 2) uphold the commentaries and responses of speakers; 3) repair interruptions and/or disruptions in communication produced by untimely or inappropriate speaking in interactions; 4) elicit speaking from other interactants (e.g., when silence is “made” following a question or when silence is given in response to a question[s]); 5) stall interactions (e.g., when silence is made to persist when given in response to the commentaries or questions of other speakers); and 6) open the floor for the speaking of others interactants.

While this is intended to be neither a prescriptive nor exhaustive list of the interactional functions of communicative silences, it does provide the beginnings of a kind of Gricean sketch (though not normative maxims) of what might be called the discourse roles of silence. Using these preliminary discourse roles as a guide, it is possible to undertake a systematic description and analysis of the making and movement of communicative silence in the cross-cultural centro de salud consultation discussed in chapter 3.

A brief discussion of the approach I apply is required prior to my undertaking the analysis owing to the unconventionality of proposing a structural analysis of the discourse roles of making silence in communicative interactions. The linguistic categories of communicative silence, like the more conventional categories used by linguists to describe speech in conversation and discourse analysis, are formulated to accommodate both detailed description and broad usage. The focus of the description and analysis of communicative silence is positioned between the who and the what of making silence. This means that while keeping in clear ethnographic sight the sociolinguistic significance of who is making silence in a given interaction, we do not neglect the larger structural considerations of what making silence communicates and accomplishes interactionally, that is, what it accomplishes beyond what individual makers of silence might want (or understand) their silence to mean in any particular instance. Perhaps best described as the “dialectics of silence”—the interconnective patterns of the use of silence in communicative actions—this approach seeks to facilitate a description of a heretofore little examined aspect of the participatory structure of communication, the polyphonic character and simultaneity of the actions of speaking and making silence.
Figure 7

Bar 7.

WS: Yes. Yes, there was.

B: Yes.

C1: Yes. So then...

C2: Yes. There was.

D: Eight days? Was there alleviation with those capsules?

And how much time has it been now?

C2: Yes. Yes.

C1: Yes.

B: Yes.

WS: Yes.
Using these descriptive and analytical tools, I now examine some of the sociolinguistic categories and configurations of communicative silence in the cross-cultural biomedical encounter at the centro de salud. In addition to showing how the simultaneity of speaking and making silence conditions meaning, the analysis enables us to consider whether making silence might also be understood as an equal but unheard voice in the polyphony of communicative interactions.

With respect to the descriptive notations used to represent the interactants’ communicative silence, observe figure 7. In staff 8, the shaded portions of the lines identify instances where interactants are making silence.5 The various discourse roles that communicative silence plays in the interaction are identified and written in italics within the shaded areas along the blank space in staves. So as to not confuse references made to the speaking of interactants with those made to their communicative silence, I identify the latter by inserting a superscripted “s” in parentheses after the abbreviations, for example, WS:8(s). A subscripted number in the standard notation refers the place of the communicative silence made by a speaker in the same bar—for example, WS:8(s), refers to the first communicative silence made by the wellness seeker in bar 8.

I begin the analysis of communicative silences as I did the analysis of speaking, by following the communicative interactions of the five participants (i.e., WS, B, C1, C2, D) in the cross-cultural clinical encounter throughout the twenty-six bars that compose the polyphonic score. Identifying communicative silences and quantifying their distribution throughout the score reveals that the discourse role that interactants most frequently conferred on making silence was that of communicative action that sustained the floor for the participant(s) who are in speaking.

Bar 8 of figure 7 illustrates some characteristic examples of the making of communicative silence in an interaction that functions semantically to sustain the floor for interactant(s) participating in speaking. Moving from left to right across bar 8 shows that while the physician is asking, “¿Y cuanto tiempo tiene que ya dejó de tomar las cápsulas?” (D:7–8) (“And how much time has it been since she stopped taking the capsules?”), the wellness seeker and her first and second companions are simultaneously making silence (see WS:8(s), C1:8(s), C2:8(s)). Their
communicative silence fills the semantic role of sustaining the floor for the physician's turn of talk. Seeing the participatory structure of turn taking in this way, that is, as being simultaneously co-composed of the acts of speaking and making silence, suggests a kind of hidden, Escher-like, interreactive play between “figure” and “ground,” speaking, and making silence.

I say “hidden” because focusing on the “figure” or speaking, which is written and in plain view in transcripts, tends to conceal the “ground” or making silence, which is in the background, unheard and underrepresented. The light that the polyphonic approach shines on communicative interaction shows that “figures,” acts of speaking, have their interreactive “shadows,” acts of making silence; the one strides ahead or behind the other, measure for measure, and the two are inseparable. From the view of a polyphonic analysis, therefore, it can be said that within the simultaneity of communicative interaction, turns of talk are
only “taken” by speaking to the extent that they are “given” the floor by interactants actively involved in making silence. As further analysis of the interactions in bar 8 and other bars demonstrates, the co-occurrence of speaking and the communicative silence that sustain the floor are not the only combination of communicative action that condition meaning in clinical encounters.

Bar 8 also shows the co-occurrence of participants making communicative silence that elicits speaking from others; see WS:8\((s)\)_2, C1:8\((s)\)_2, C2:8\((s)\)_2, and D:8\((s)\)_2 in figure 8. Note that in bar 8 after asking the question “And how much time has it been since she stopped taking the capsules?” the physician makes communicative silence (see D:8\((s)\)_1). Here his silence interactionally fills the discourse role of eliciting a response from the wellness seeker and her two companions. For their part, the wellness seeker and her two companions’ answers (see WS:8\((s)\)_2, C1:8\((s)\)_2, C2:8\((s)\)_2) to the physician’s silence also serve the role of eliciting.

While the discourse roles that each of their making silence plays within the interactions of bar 8 have mutually intelligible interactional significance (i.e., eliciting) what is being elicited by their silences is slightly different. The physician is eliciting a response to his question, and the wellness seeker and her two companions, in making and giving silence as a response to the physician’s question, are eliciting additional information and/or clarification of the physician’s question. The physician interactionally acknowledges the significance of their communicative silences and restates his first question, clarifying it as “¿Ya no está tomando las capsulas cuanto tiempo hace?” (D:8) (“Now she’s not taking the pills, how much time has it been?”).

It bears mentioning that conventional discourse and conversation analysis that privileges speech as presence and “doing” would have likely overlooked the unspoken contributions of making silence to the configuration of this communicative interaction. For example, approaching this same sequence from the view of conversation analysis might suggest that by conversational rules (Sacks et al. 1974), the completion of the physician’s utterance “And how much time has it been since she stopped taking the capsules?” shifts the floor (i.e., the turn of talk) to its recipient for an answer. Furthermore, when an answer is found aurally absent, conversational rules also dictate that the asker (in this case the
Excerpt of Nima's Cross-Cultural Consultation

25) D: And how much time has it been now that she stopped taking the capsules?

26) D: Now, she's not taking the capsules for how long?

27) C2: Was there one, how many, one month now that there weren't any?

28) C2: Well, she's not taking the capsules for how long?

Figure 8

Polypophonc Score

Bar 8.
Physician) take the next turn, initiating a “self-repair” or self-correction. Though this kind of analysis can reveal much about the structure of floor allocation and turn construction, it is grounded in presuppositions about speech as “presence” and doing that can conceal other subtle aspects of the interaction. Interpreting the silences that the wellness seeker and her companions make following the physician’s question as a “nonanswer” assumes that making silence is incapable of being a communicative action that, like speaking, “takes a turn.”

As figure 8 demonstrates, a conventional transcript of this same interaction (also observable in figure 7) provides a dramatically different representation of the participants’ communicative contributions to the participatory structure of the interaction. From an analysis of lines 25–27 of the transcript there would be little way of discerning who and/or what prompted the physician’s follow up question in line 27. It would be possible to conclude from the conventional transcript (as other studies of language used in health care with like data and analytical techniques have done) that the physician is simply controlling the floor, that this was a classic case of interactional asymmetry (for an exception see Keating 1998). This interpretation, however, has the affect of reducing the communicative field to speaking and in so doing it (inadvertently) overlooks the silent contributions of sensing and expressing that participants offer to an interaction by making silence.

**SILENT COMPLICATIONS IN CLINICAL COMMUNICATION**

Given that speech has been the primary criterion for “who” and “what” is represented in transcriptions of doctor-patient interactions, it is easy to understand how the absence of speech on the part of the patient in some clinical interactions has frequently been interpreted as sociolinguistic evidence of disempowerment and clinical asymmetry. However, being able to “see” the inaudible making of silence as structured and meaningful communicative acts in the polyphonic score provides a different view of such interactions. Applying this approach in other studies might one day lead researchers to draw different conclusions about the sociolinguistic power structures of doctor-patient talk based not only on who is speaking but also on who is present and interacting communicatively without words.
A polyphonic analysis of bar 8 of the score (see figure 9) illustrates that the discourse roles that making silence interactionally fulfill can and do condition meaning in an interaction. The shaded areas of the score, representing communicative silences, show that only after the physician recognizes the significance of the wellness seeker and her companion's communicative silences does he restate his question. Moreover, it is only after he restates his question, following it with more communicative silence (D:8(s)2) that has the discourse of eliciting does the second companion relate his question to the wellness seeker in K'iche'(C2:8–9). But is it the restatement of the physician's question that brings forth a response from the second companion, or the fact that the physician, following his question makes silence that elicits, or both?

To answer this question I briefly reexamine the complications in clinical communication that occur in this biomedical encounter. The relevant portions of the score, bars 4–5, appear in figure 10. Recall that the physician unknowingly contributed to the problems in miscommunication by asking questions in a manner characteristic of the medical interview. He asked four questions in rapid succession, and only his final question was given an answer. Now, in light of the discourse roles of making communicative silence, what else might be said about the original communicative complications I have identified? Might it be suggested that the communication problem should not be solely understood as resulting from the physician asking four questions in succession but also from his not making the required communicative silences (after each question) that would have fulfilled the critical discourse role of eliciting a response (see D:4–5)?

We can return as a point of comparison to the graphic representations of “communicative silences” in bar 8 (figure 8), which show that in each instance where the physician makes silence that elicits (following his questions), he receives a response (D:8(s)1 and D:8(s)2). It can be said, then, that syntactically well-formed questions, when not followed up with the necessary dialectical silences that elicit, are missing a relational component to their meanings that can cause them to go verbally unanswered.

Turning our attention now to the graphic representations of making silence illustrated in bar 10 (see figure 9), we can see that the score shows that the discourse roles that communicative silence fulfill are not
limited to sustaining the floor or eliciting responses. An examination of the simultaneity of speaking and making silence in bar 10 (across the staves) reveals a dialectical interactional structure that is polyphonic; that is, composed of multiple voiced and unvoiced contributions of full-fledged subjects. Here, participants can be observed adding their voices to the interaction by alternately contributing speaking and communicative silences in various quantities. An examination of bar 10 shows the ebb and flow of speaking and communicative silences as a dialogic emergence moving between the interactants in a kind of rhythmic exchange of words for silence and silence for words.

Following the interactions of speaking and communicative silence across bar 10 from left to right shows two instances of the first companion making silence that repairs. When the physician asks, “¿Mientras tomó las pastillas estuvo bien?” (D:10) (“While she took the pills she was well?”), the first companion interjects saying, “Sí” (C1:10) (“Yes”), before his question is completed. Note that the first companion’s interjection of “yes” overlaps the physician as he is saying “she was . . .,” but it does not interrupt him or cause him to stop speaking. He completes his question. Therefore, the communicative silence that the first companion makes (C1:10(s2)) directly following her own interjection fills the discourse role of repairing any disruption caused by her speaking while the physician held the floor.

Because the first companion’s interjection of “yes” did not interrupt the physician’s speaking in the first example, it was perhaps not essential here that she make silence to repair the floor. The same, however, cannot be said of her second interjection in bar 10 “Está . . .” (C1:10) (“She is . . .”). Examining bar 10 shows that when the physician says “Ahora, ehh . . .” (D:10) (“Now, uhh . . .”) the duration of his hesitation fills the discourse role of a communicative silence that functions interactionally to open the floor for another interactant to take a turn of talk. The first companion, interpreting the physician’s hesitation as opening the floor, interjects, “She is . . .” Her interjection interrupts rather than overlaps because the physician does not continue to speak (see the co-occurrence of speaking and making silence in C1:10 and D:10(s2)).

The first companion acknowledges the untimely nature of her saying “She is . . .” before the floor has been properly opened and follows her interjection by making silence that fills the discourse role of
Excerpt of Nima’s Cross-Cultural Consultation (English)

Bar 10.

WS: [sustains] [upholds] [sustains] [upholds] [sustains]:WS
B: [sustains]:B
C1: [sustains] [repairs] [sustains] [open]:C1
C2: [sustains] [upholds] [sustains] [upholds] [sustains]:C2
D: [question]:D

Excerpt of Nima’s Cross-Cultural Consultation (Spanish)

Bar 10.

WS: [sustains] [upholds] [sustains] [upholds] [sustains]:WS
B: [sustains]:B
C1: [sustains] [repairs] [sustains] [open]:C1
C2: [sustains] [upholds] [sustains] [upholds] [sustains]:C2
D: [question]:D

Polychronic Score

Figure 9
repairing the floor. The physician interactionally recognizes the first companion’s communicative silence that repairs and returns to speaking, asking, “¿Otra vez?” (D:10) (“Again?”). Ironically, it is the rupture in the participatory structure of an interaction, a breakdown in the simultaneity of the exchange of words for silence and silence for words that draws attention to the absence and necessity of communicative silence in interaction. The physician, for his part, diffuses the interruption and mends the rupture by appearing to “take up” or incorporate the first companion’s untimely interjection into the formation of his question. In doing this, he produces a near contiguous utterance, combining the first companion’s “She is . . .” with his “Again?” to create a question whose significance might be something like, “She is [sick] again?” The physician follows this up with more interactional latching by asking “the problem returned?” (D:10).¹⁰

**ON THE RESPONSIVENESS OF SILENCE**

You tell me that silence
is nearer to peace than poems
but if for my gift
I brought you silence
(for I know silence)
you would say
This is not silence
this is another poem
and you would hand it back to me

Though at this point we have analyzed examples of the discourse roles of communicative silence that interactionally function to sustain, elicit, repair, and open, bar 10 offers an additional discourse role of making silence not yet discussed. While bar 10 shows the wellness seeker and her companion initially making silence that sustains, the wellness seeker also makes silence that fills the discourse role of interactionally upholding the responses and contributions of the other interactants (see WS:10⁽⁵⁾₂ᵃ⁾.

Further examination of bar 10 reveals that it is possible to distinguish between when the wellness seeker is making silence that sustains from when she is making silence that upholds. This distinction is based on whether or not her communicative silence co-occurs with
an interactant’s question or with an interactant’s response. As already noted, when an interactant is asking a question (e.g., D:10) and another interactant is simultaneously making silence, the discourse role that her communicative silence fills is to sustain the floor (see WS:10(s), for the interactant who is speaking. Conversely, when the companion of the wellness seeker is responding to a question (for which the wellness seeker is a potential respondent) and the wellness seeker makes silence during her companion’s response, the discourse role that her silence fills is that of upholding the interactant’s response (see WS:10(s),).

Specifically, when the physician asks, “While she took the pills she was well?” and the first companion responds, “Sí, estuvo bien” (“Yes, she was well”), the silence that the wellness seeker concurrently makes functions interactionally to uphold her first companion’s response. It should be noted that analyzing the wellness seeker’s communicative silence as upholding another interactant’s response does not mean she agrees with that response but rather merely describes the discourse role that her making silence fills and the interactional significance it produces. What making silence communicates by the discourse roles that it fills is accomplished interactionally. That is to say, the silence that the wellness seeker (or any other participant) makes in an interaction has sociolinguistic significance beyond what the individual maker might want her or his silence to mean in a particular instance or context. This is true of all of the discourse roles of communicative silence that I have discussed here, in that the meanings that they are assigned in the interactional field are more the patterned product of a speech community’s sociolinguistic expectations and less the creation of an individual interactant’s will or intent (see Philips 1976; Knack 1991).

Where multiple participants add voices and experiences to clinical encounters, as is the case in Nima’, the implications of the making of communicative silence that upholds can be profound for the outcome of care. An examination of communicative silences that uphold in the score shows that when a potential respondent to a question makes silence concurrently while another interactant verbally responds to that question, the uttered response is interactionally accepted. By “interactionally accepted” I mean that no further or qualifying questions are asked of other interactants (i.e., the potential respondents) to verify upheld responses. The score shows that this practice of interactional
acceptance is true for upheld responses given to questions asked by the physician as well as upheld responses given to questions asked by the first and second companion. It can be suggested, then, that when upheld responses in multivoiced clinical interactions go without being followed up by clarifying questions, the potential for misunderstanding of participants’ responses and communicative silences is greater.

Beyond identifying and describing the presence of the various categories of communicative silence, following their movements or distribution between participants in curative encounters provides valuable insights into sociolinguistic relationships. For the K’iche’, the making of communicative silences that uphold does not (as one might expect) produce a homophonic participatory structure or a monologic telling of illness narratives. On the contrary, because (as we have seen) K’iche’ achi’il participation in curative interactions is polyphonic and because illness narratives are told in multiple voices, the wellness seeker is not the only interactant that makes silence that upholds.

A brief return to our analysis of the interactions in bars 5 and 6 shows that the wellness seeker can also be on the receiving end of having her voiced responses upheld by the unvoiced communicative silences of her companions. When the second companion is responding to the physician’s question saying, “Le dijeron es . . .” (C2:5–6) (“They told her it’s . . .”), the wellness seeker interjects saying, “Es úlcera o . . .” (WS:6) (“It’s an ulcer or . . .”). Here, the wellness seeker’s interjection interrupts the second companion’s response. The second companion makes silence during the wellness seeker’s interruption, and this silence (see C2:6 (s)) has the discourse role of upholding the wellness seeker’s response “It’s an ulcer or . . .”

Notice also that the physician makes silence that sustains the floor (D:6 (s)) during the wellness seeker and her second companion’s co-composition of the illness narrative. Following the movements of communicative silence that upholds reveals that the presence alone of silence that upholds is not an indicator of sociolinguistic asymmetry in the clinical encounters. In fact, as this demonstrates, the distribution of making silence that upholds between the various participants interactionally contributes to the multivoiced coauthoring of meaning and understanding.

This analysis of the discourse roles of communicative silence shows that the voice of silence, though inaudible and laying in shadows on the
Excerpt of Nima’ Cross-Cultural Consultation

Bar 4.

WS: B: C1: C2: D: Uh, on the last time what did I say you had?

Bar 5.

WS: B: C1: C2: D: Uh, what... what... was the essence of what he gave you?

They told her... C1: C2: D: treatment, what, what pills or what was it that we gave you there? What was it that I said you had?

C1: she says that it has come again. Sometimes it [the pain / illness] makes her stomach swell at night and in the day.
other side of speaking, is expressive, contributing to interactions and conditioning meaning. Seeing the making of silence as “presence” and as a full-valued way of interacting communicatively promises to contribute much to linguistic analyses of interactions in general and to the study of complications in medical communication in particular.
5
A CALL TO COMPETENCE

Metalogue (Logos about Logos)

Man kinch’ob’ taj, qas tene’ le qe le in ktz kixtzijon pa qach’ab’al. E
kincholo da’ qas kinb’ij tzij bien kinta como la’ le kinta’ ti in le castill.

(I didn’t understand [the medical advice], it’s not like it is with us, you
all speak K’iche’. I can understand the story, I can say the truth, and I
understand it when it’s said [but] I don’t understand Spanish.)
—Juana Xik, 2001

SYNCRETIC THERAPEUTIC SETTINGS

Shifting our attention from cross-cultural biomedical to intracultural
therapeutic care, the consultation that we examine in this chapter
unfolds at the dispensario between a K’iche’ wellness seeker, her rachi’l
(companion), and a Maya theurgical herbalist. The epigraph comes
from a dispensario consultation, during which the wellness seeker,
Juana Xik, in retelling her illness narrative to the healer, describes the
contrast between Ladino biomedical and Maya therapeutic interac-
tions. In order to understand the sociolinguistic disclosures made by
the wellness seeker we examine her dispensario consultation for larger
insights into the language and culture of Maya therapeutic care.

In the ethnography of Maya peoples, the convention, with regard
to anthropological inquiries into healing practices, has been to investi-
gate “traditional” healing and more recently health seeking in bio-
médical contexts (see Huber and Sandstrom 2001; Eder and Garcia Pú
2003; Adams and Hawkins 2007), leaving emerging syncretistic medi-
cal modalities like everyday wellness seeking at dispensarios (Harvey
2003) or with Maya mobile medical vendors (Harvey 2011) that are
neither strictly definable as “traditional” nor “biomedical” underinvesti-
tigated. Listening for the unheard voices of Maya wellness seeking took
this investigation into the Nima’ dispensario, located on the grounds
of the Catholic Church in Nima’ and operated with support and personnel from the clergy and town’s parishioners (see R. Wilson 1995). Open to the public seven days a week, it provides a modestly stocked pharmacy as well as outpatient therapeutic consultations. Prior to the arrival of the current Catholic priest, Padre Geronimo, a K’iche’ Maya from Totonicapan, the dispensario in Nima’ existed only as a medicine cabinet set up to meet basic needs. In 1998 Padre Geronimo and his assistant Miriam, expanded the dispensario to two rooms consisting of a pharmacy and a consultation area (Harvey 2006a).

The primary therapeutic practitioner at the dispensario was Miriam, a middle-aged Maya woman from the K’iche’-speaking town of Momostenango. She brought a unique background to the dispensario, having been trained as both a Maya ajkun in her hometown and as a certified nurse at a university in Guatemala City. During Miriam’s time living and working at the Catholic Church in Nima’ she met Laura, a Nima’ native, who became her companion, co-worker, and confidant. After undergoing three years of training at Miriam’s side, Laura began working full-time at the dispensario as the tob’anel rech ri ajk’un (healer’s helper). Together, they managed all aspects of the dispensario from bookkeeping to planting and harvesting medicinal plants to performing spiritual therapeutic consultations.

The therapeutic treatment that Miriam and Laura provided at the dispensario syncretistically combined sacred (Maya/Catholic) and secular (biomedical) approaches to wellness, illness, and care. As my ethnographic analysis of the dispensario consultation shows (and as other studies have documented), in Maya therapeutic interactions, prayers and medicines are frequently linked in healing and offered to wellness seekers alongside one another (e.g., Meztger and William 1963:218). This, as Richard Wilson points out with reference to the Q’eqchi’ of Alta Verapaz, Guatemala, is because among Maya peoples, healing has been inextricably linked to religious practice, and unlike in biomedical models of care there is no presupposed separation between the two (R. Wilson 1995:196).

Given the spiritual and religious component to dispensario therapeutic care, the social role that Miriam and Laura occupied as healers within the community can perhaps be best described as theurgical herbalist. That is, they were healers who invoked supernatural or divine
agency to *achi’laxik* (accompany) their herbal and pharmacological treatments of the sick. As I show with specific reference to the therapeutic interactions that follow, the spiritual and religious components of *dispensario* healing reflect the frequently cited syncretism of Maya and Catholic elements in spiritual and religious practices in Guatemala (see Mondloch 1982; R. Wilson 1995; Cook 2000; Sáenz Hernández and Foster 2001; Samson 2007).

Comparatively speaking, the *dispensario* is relatively well attended by the townspeople of Nima’. On average, there were eight or nine visitors seeking full therapeutic consultations at the *dispensario* on any given day compared with twenty patients at the *centro de salud*. Added to this number were about another fifteen people per day who come for advice on *remedios* (remedies) and/or to purchase medicines from the pharmacy. The freedom of wellness seekers to request and receive informal health care advice from healers without undergoing a formal consultation and the ability to purchase medications based on that advice are some factors that distinguish local participation in therapeutic care from their participation in biomedical care (see Harvey 2011).
In addition to locals, the dispensario also attended to Ladino and Maya wellness seekers (from various parts of Guatemala) who had either heard of or had positive experiences with its healers.

**DEMOGRAPHICS OF WELLNESS SEEKERS**

The majority of wellness seekers who visited the dispensario were women and their children (about 73 percent). The rest consisted of married men who accompanied their wives and family members into the consultations (21 percent) and young unmarried men who visited the dispensario alone (6 percent). The higher percentage of women wellness seekers, as other studies in Guatemala have pointed out, may primarily owe to the larger role that Maya women play in healing and in the care surrounding the rearing of children (e.g., Cosminsky 1972; Jordon 1993; Wilson 1995). Reproductive health, pregnancy, and infant care (primarily the charge of women among the Maya) are all domains of Maya therapeutic care that women (e.g., iyomab’) participate in more than men, both in the giving and seeking of care. Similarly, Maya men tend to seek therapeutic treatment from predominately male Maya
ajpab’aqab’ (bonesetters) more frequently than do women because of their primary role in nonmechanized subsistence crop production, from which musculoskeletal injuries are commonly incurred (see Redfield and Villa Rojas 1934; Cosminsky 1972; Fabrega and Silver 1973; B. Tedlock 1992b; Hinojosa 2002, 2004). To these distinctions, noted at the time of the investigation, we add recent investigations into marginalized forms of medical care in Guatemala that show that Maya men are more likely to seek health care from traveling Maya medical salespeople than women (Harvey 2011). Countering these gendered trends related to where treatment is sought and from whom it is sought are spiritual therapeutic consultations with Maya aq’iq’ab’ and ch’ob’onelab’ (seers/diviners), both of which are sought equally by men and women (regardless of their social or socioeconomic assignments) and with nearly the same frequency.

Another element in the functioning of dispensario care that bears mentioning here—and that no doubt affected patronage—was its hours of operation. Miriam, who lived in the parroquia (parish), received wellness seekers at the dispensario at any hour of the day or night. Likewise, when Laura (the healer’s helper) left the dispensario for the evening (generally after 5:30 p.m.) and her assistance was needed after hours, the church’s housekeepers, Talin and Ma’t, would act as messengers, running across town to Laura’s home to notify her of such situations. My memories of these after-hour therapeutic calls are quite vivid; a brief ethnographic recollection of a typical scene provides a glimpse:

After a full day of agricultural work in the fields, I had fallen asleep in the late afternoon and awoke to sounds of tiny knuckles batitng the wooden door to my room—children’s voices in hall, calling through sleep a familiar name. “Come, there’s one sick, Miriam says come to the dispensary. Come!” I grabbed my things and followed the sounds of footfalls and sandaled feet that disappeared before me around the next bend through the long parish halls. When I arrived at the dispensary and entered the ill-lit consultation room, I found a middle-aged man sitting across from Miriam, a Maya theurgical herbalist, and her assistant. (2006a:3–4)
HEALERS, “SOME WERE CALLED, SOME WERE SENT, AND SOME JUST WENT”

A closer look at these visitor-friendly hours provides an unlikely glimpse into the presence of Maya therapeutic ethics and principles at work in dispensario care. Like other Maya ajkunab’, Miriam and Laura explain their willingness to heal whenever and wherever as a “calling” and their duty to their don (see K. Wilson 2007). This “don” (distinguishable from the honorific, e.g., “don Ramon”) is linked to the individual’s uwach uq’ij (essence of one’s day/light and destiny) (Bunzel 1981; L. Paul 1978; Paul and Paul 1975; Greenberg 1982; B. Tedlock 1992a) and corresponds to the individual’s specific q’ij of birth on the Maya calendar (Hart 2008). The don is related to the force that one’s day of birth exerts on the life-world, ability, and potential (Alvarado 1999; Hurtado and Sáenz de Tejada 2001; Walsh 2009). It is at once a gift, an ability, the life’s light, and simultaneously a noblesse oblige to that light and that destiny.2

The reasonably high volume of Maya visitors to the dispensario can be attributed to several additional factors. One of these factors is expressed in the wellness seeker’s quotation that serves as the epigraph to this chapter, and it relates to the language and culture of care. The Maya of Nima’ expressed an overwhelming preference for K’iche’ as the language of care, not only in their responses to my ethnographic inquiries but also in their interactions with each other.3 In this respect, Miriam’s cultural and sociolinguistic positioning as healer at the dispensario in Nima’ was quite complex in terms of how it affected wellness-seeker attendance.

While Miriam’s use of K’iche’ in her social and therapeutic interactions with townspeople benefited the dispensario because it was consistent with local expressions of language preference, her lack of local kinship ties her distinctive cultural dress, and her communicative practices worked to arouse suspicion, announcing her as a non-Nima’ native; this was the social role within which she was placed and from which she interacted.4 Her understanding of how to counter the ethnic and sociolinguistic distinctions that provoked misgivings about her—and consequently the dispensario—formed K’iche’ cultural and “communicative competence” (D. Hymes 1974).

Though recognizably Momostecan, in Nima’ Miriam was nevertheless in local terms natural winaq (indigenous person) and not a xnu’l (nonindigenous) Spanish-speaking Latin American woman. That
Miriam was Maya and that she was assisted by Laura, a Nima’ native, worked to foster a degree of public confidence in the treatment and services offered at the dispensario. It is worth noting that the dispensario also greatly benefited from its being created and endorsed by the wildly popular and dearly beloved K’iche’ Catholic priest, Geronimo, who was one of only a handful of Maya Catholic priests in Guatemala.

**WAYS OF SPEAKING IN MAYA HEALTH CARE**

Having begun setting the scene for therapeutic care at the dispensario, I now examine bars 1–6 of the polyphonic score of an intracultural therapeutic consultation recorded there. The complete score of the consultation in its entirety can be found in appendix C and an English translation in appendix D. The following are the abbreviations for the participants involved in the consultation: WS = wellness seeker; C = companion; and H = healer. In the therapeutic interaction that follows, Miriam conducted a consultation, while Laura attended to visitors in the pharmacy. The wellness seeker, Juana, who was thirty-two years old at the time, and her companion, Lu’s, her cousin, who was in her mid-twenties, are Nima’ natives. While not close acquaintances of Miriam, they both knew her through their participation in various social and religious activities sponsored by the Catholic Church. Though I was present for a portion of the consultation, I was not, as Goffman would put it, a “ratified” participant (1981:9–10) and therefore do not have a line in the staff that appears in the score.5

**COMMUNICATIVE COMPETENCE IN MAYA THERAPEUTIC CONSULTATIONS**

A close look at the interactions in bar 1 shows that while the healer appears to open the encounter with the two-part question, “Su kub’ano le apam, le ajolom?” (H:1) (“What is the essence of what your stomach is doing, and your head?”), the contents of her inquiry suggest some prior knowledge of the wellness seeker’s condition. What else might account for Miriam beginning by asking Juana specifically about her stomach and head? In fact, what eluded the audio recording but passed through the ethnographic lens of participant observation were the interactions of healer and wellness seeker that occurred moments before the recording began.6
Bar 6.

WS: Are le nervio kucham, el nervio kucham, kucham.

C: Mhm.

H: Mhm. Je kucha la a rote.

WS: K, veces gas e chajap e. Khymun, Khymun, khymun, Khymun kucham war ti como va xka, sile nung, khile, chik hile.

C: Aje e.

WS:

Bar 5.

WS: E k'ut, kajap pa taq nuq'ab' k'i karakaratik are k'u la le nervio. Parece nervio k'u la karakaratik je kub'an, l'e, ri'

C: Mhm.

H: Mhm. Mhm.

WS: Mhm, ri karakarat che le numpam. Qas uwach e k'o veces Khymun pa nixkin y' kiz intihik.

Bar 4.

WS: Mhm.

C: Mhm.

H: Mhm.

WS: Mhm, kacaj pa lag mug, k'i karakaratik are k'u, la le nervio. Parece nervio k'u la karakaratik je kudab, le ri'.

Bar 3.

WS: Mhm.

C: Mhm.

H: Mhm.

WS: Mhm, kacaj de nergio k'u le Kugua, pa lag mug, pa lag mug, kacaj de nergio k'u le silencio.

Bar 2.

WS: Mhm.

C: Mhm.

H: Mhm.

WS: Mhm.

Bar 1.

WS: Mhm.

C: Mhm.

H: Mhm.

WS: Mhm.

Bar 0.

WS: Mhm.

C: Mhm.

H: Mhm.

WS: Mhm.

Polypirno Score

Figure 11
Bar 1.
WS: Uh . . . well, my head hurts with sustained pain, my head hurts, and like my spirit.
C: What is the essence of what your stomach is doing, and your head?
H: Yes. Yes.

Bar 2.
WS: They burn. And the nerves. Yes, they dropped to my feet and to my hands, burning like being next to fire and coming directly to my head.
C: Yes.
H: Yes. Hmm. Yes, that is what she hears?

Bar 3.
WS: Then, it descends to my hands, constantly scratching. This is because of nerves. Then, it's nerves, this is the constant scratching it makes. Look.
C: Well, my head hurts with sustained pain, my head hurts, and like my spirit.
H: Yes.

Bar 4.
WS: This, this, scratching my stomach. And I say, Juana. . . What is the essence? . . .? And I say, Juana, . . . what is the essence? . . .? What is the essence? There are times that it hums in my ear and it rings.
C: Yes. There are times that it hums. It hums. If it hums, it leaves this area as if there were now silence there.
H: Yes. Is that what she hears?

Bar 5.
WS: Yes, only nerves do this, I say. That's right. And I say, Juana, . . . what is the essence? That is because of nerves. Then, it's nerves, this is the constant scratching it makes. Look.
C: That's it, it's the nerves that do that . . . such is the case, only it's the strength/force that is.
H: Yes.

Bar 6.
WS: And the nerves, yes, they dropped to my feet and to my hands, burning like being next to fire and coming directly to my head.
C: Only nerves, only nerves do this, I say. Yes. Yes.
H: Yes. Hmm. Yes, that is what she hears?

Bar 7.
WS: Yes. Is that what she hears?
C: Yes. Yes.
H: Yes.

Bar 8.
WS: Only nerves, only nerves do this, I say. Yes. Yes.
C: That's it, it's the nerves that do that . . . such is the case, only it's the strength/force that is.
H: Yes.
It is a common communicative practice in Maya spiritual/therapeutic encounters that the wellness seeker or her/his companions rather than the healer initiates the verbal action in the consultation (for a Yucatec example of this Maya communicative practice in therapeutic interactions, see Hanks 1999:234). It bears mentioning that in Nima’, Maya sociolinguistic expectations were that it was the role of wellness seekers and/or their companions to initiate medical encounters with “illness talk”; this contrasts sharply with the conventions of biomedical encounters that call for health practitioners, not patients, to open consultations with small talk and questions (see Harvey 2008a). These sociolinguistic variations can put the communicative competencies of Maya wellness seekers and those of biomedical health practitioners at odds with one another and cause complications in cross-cultural care (see Leblanc et al. 2009).

Once the wellness seeker and her companion had greeted Laura and checked with her to see if Miriam was receiving visitors, they passed through the pharmacy and stood at the doorway of the consultation area. Without looking into the room in which Miriam sat, they each paused and then called into the room, “La at k’olik? La at k’olik?” (“Are you there? Are you there?”). Miriam responded, “K’olik!” (“There/present [I am]!”), adding “Toq loq le tem” (“Draw near, bring a chair from there to here”). As they entered the ill-lit room Miriam stood up and they exchanged greetings before sitting down near one another. Here Juana, not Miriam, opened the therapeutic consultation. Juana initiated the encounter with a brief account of her ailment, which was followed by her companion, Lu’s, asking Miriam if she would give them a consultation.

To pause at doorways and thresholds, as other researchers have noted in other studies of Maya peoples, is a comportment practice that physically links the making of silence to important cultural forms of respect (see Molesky-Poz 2006). In Nima’, this was particularly true for Maya wellness seekers, who religiously paused before entering therapeutic and ritual spaces. I first made this observation not at the dispensario but on a trip with a group of Maya ajq’ijab’ and ch’ob’onelab’ whom I accompanied to do chak (ritual therapeutic work) at the mountainside altar of K’atel Ab’aj (Burnt Rock). After an hour of hiking and climbing we stopped short of the summit, pausing before two mounds of burnt rocks that formed the gateway to a path that extended onward, beyond
the precipice and into the heart of a great stone crevasse, the altar of K’atel Ab’aj. Pausing and praying at the stone gate, each healer, seer, wellness seeker, and companion genuflected before crossing over into the sacred ritual space.

Juana and Lu’s stopped at the doorway to the *dispensario’s* therapeutic space, pausing to show both social and spiritual respect. Just as the Maya shamans and seers had stopped on the mountain path to pray, they too stopped and made the appropriate greetings and only entered once permission was granted. Enacting these silent communicative and sacred comportment practices is a way of showing deference toward and of honoring spirit-filled, sacred places and the practitioners who tend to them. As such, these practices are observable in a wide range of Maya spiritual and therapeutic practices in Nima’ (see Levi-Strauss 1967; V. Turner 1969; B. Tedlock 1992b; Molesky-Poz 2006; Hart 2008).

In initiating a Maya therapeutic interaction, Maya wellness seekers will (as Juana and Lu’s did) ask whether or not an *ajkun* or an *ajq’iij* is *k’olik* (there/present). Wellness seekers will do this even when it is known or has been confirmed beforehand that the healer or shaman is present. The practice allows the wellness seekers to show respect and provides practitioners with the opportunity to issue the sociolinguistically appropriate responses of *k’olik* or *k’o taj* (not there/absent). Interestingly, a response of *k’o taj* from the spiritual/therapeutic practitioner does not appear to Maya wellness seeker as either odd or even untrue. Indeed, a response of *k’o taj* is not (as it may at first seem) a denial of the practitioner’s physical presence, the fact of which their voice and very response to the inquiry would unavoidably attest to. Rather, the therapeutic healer or shaman who responds to a wellness seeker with *k’o taj* is socially understood as offering a self-effacing and humble denial of their status and ability as healer and/or shaman. The response of *k’o taj* from a therapeutic practitioner says to wellness seekers that “the personhood of healer or shaman whom you seek is absent,” while showing them, with an embodied voice that answers from within the ritual space, that someone is, nonetheless, there (see Durkheim 1995; Mauss 1985; Mentore 2005). In addition to this, a response of *k’oj taj* also enables healers, after examining wellness seekers, to decide not to treat an illness given their aforementioned denial of ability (see Metzger and Williams 1963:217).
ROLE OF QUESTIONS IN MAYA THERAPEUTIC AND BIOMEDICAL CONSULTATIONS

Returning now to bar 1, we examine the healer’s opening question, “What is the essence of what your stomach is doing, and your head?” Notice that although Miriam asks a two-part question, only the last portion (“and your head?”) appears to receive a response from Juana:

Ah . . . porese le nijolom kaq’oxowo k’u la. Kaq’oxowik le nijolom y le wanima’ le mism keq’aq’anik. Y le nervio je kuqaj pa taq le waqan, pa taq nuqa’b kujululik kpetik taqal che nijolom. (WS:1–2)

(Uh . . . well, my head hurts with sustained pain. My head hurts, and like my spirit, they burn. And the nerves, yes, they dropped to my feet and to my hands, burning like being next to a fire and coming directly to my head.)

As we have already discussed with regard to the cross-cultural biomedical encounters at the centro de salud, the asking of multiple questions has been described as a communicative practice characteristic of biomedical interviews and doctor-patient interactions.

The initial interaction between Miriam and Juana suggests that perhaps the same can be said for asking two-part questions in therapeutic interactions between Maya healers and wellness seekers. That is to say, only the final portion of the question will likely receive an answer from respondents. However, a closer look reveals that this is not the case in this example. If we follow Juana’s response through to bar 4, we see that she briefly address the healer’s inquiry about her stomach saying, “Le ri, ri. Karakarat che le numpam” (WS:4) (“Look, this, this. Scratching my stomach”). Juana elaborates even further on her stomach problems in a delayed response, whose interactional significance I address below, that occurs over halfway through the consultation (see bars 45–46 of appendixes C and D). It was Virginia Hymes, recounting her research among Warms Springs Saphatan peoples (1975) that first alerted me to the wide range of linguistic variability in response times to questions and more importantly to the ethnographic necessity of continuing to listen.

From a sociolinguistics perspective, an interesting issue that the structure of Miriam’s two-part question raises is whether or not there are significant similarities in the structure and quantity of questions
asked in *centro de salud* (doctor-patient) interactions and in *dispensario* (healer-wellness-seeker) interactions. If so, does Miriam’s university training in Guatemala City as a certified nurse account for a questioning strategy similar to that of a biomedical encounter? Is the encounter between Miriam and Juana, therefore, not typical of Maya therapeutic interactions in general because of the healer’s experience? Also, would Miriam’s use of such a question structure lead us to expect to find similarities in the participatory structure of interactants in cross-cultural biomedical and in intracultural therapeutic interactions?

What we discover when examining distributions of questions in the *dispensario* consultation in its entirety (see appendixes C and D) is quite remarkable. In a consultation lasting around 13 1/2 minutes, represented in eighty-two bars across fourteen pages, the healer asked a total of only fourteen questions (H:1; H:5; H:19; H:20; H:21; H:48–49; H:49b; H:51; H:51b; H:54; H:54b; H:55–56; H:59–60; H:82). Additionally, of the fourteen questions asked, only Miriam’s first question contained two parts. Following the interactions and communicative contributions of Juana and Lu’s throughout the polyphonic score reveals that the wellness seeker asked eight questions (WS:14; WS:15; WS:20; WS:42; WS:49; WS:69; WS:70; WS:73), two-thirds as many as the healer, and that her companion asked five questions (C:4; C:27; C:32; C:33; C:77). When considering this therapeutic interaction in its entirety what might we learn from the general paucity of questions from the healer and the role of questions in Maya therapeutic consultations?

Indeed, when the question—the communicative action on which many linguistic analyses of language used in medical interactions are based—becomes as scarce of a linguistic phenomenon as it does in this score, how might we proceed with an analysis of such interactions? In medical discourse analysis, have not question-and-answer sequences more than other communicative actions in clinical encounters been linked to the control of topics, the negotiation of the communicative floor, interactional asymmetry, the power to speak, the silencing of patients, and a range of other sociolinguistic and power dynamics? To explore these issues we return briefly to the cross-cultural biomedical encounter in chapter 3.

Another look at the *centro de salud* consultation shows that in an encounter that lasted just under two minutes, represented in a
polyphonic score of twenty-six bars across seven pages, the physician asked a total of twenty-three questions (D:1, D:1; D:5, D:5, D:5, D:5; D:6, D:6; D:7, D:7; D:7–8; D:8; D:9; D:10, D:10; D:11; D:12, D:12; D:13; D:14, D:14; D:15; D:24) appearing in thirteen of the total number of bars. Though the biomedical consultation only lasted about one-seventh of the duration of the therapeutic encounter (1 minute 55 seconds compared to 13 minutes 31 seconds), the physician asked nearly twice as many questions as the healer did (twenty-three questions compared to fourteen questions). Further, in the centro de salud consultation the first companion asked one question (C1:5), the second companion five questions (C2:2; C2:8–9; C2:11; C2:21–22; C2:25), while the wellness seeker and her child did not ask any questions at all, compared to the eight questions asked by the wellness seeker and the five asked by her companion in the dispensario encounter. What are we to make of such stark contrast in the participatory structure of the two consultations (biomedical and therapeutic) vis-à-vis questions and the sociolinguistic roles of doctor, patient, healer, wellness seeker, and companion?

VARIATIONS IN SOCIOLINGUISTIC EXPECTATIONS

We might begin to understand these differences by considering the language of care and specifically the medical interview. As is well documented, in biomedical clinical encounters the medical interview is the primary communicative practice through which physicians elicit information from patients (Harvey 2008a, 2008b). The canonical sociolinguistic structure of the medical interview involves the physician asking the (majority of the) questions and the patient providing the (majority of the) answers. With the significant exceptions of Maya companion and coauthored (polyphonic) responses to the physician’s questions discussed in chapter 4, our analysis of the centro de salud consultation seems to reflect this general description.

But medical interviews, like other speech events, are culturally situated and interactionally accomplished. As social and linguistic phenomena they necessarily presuppose a certain set of relationships and require a particular kind of communicative competence that reflects participants’ investment in those roles and their expectations. The sociolinguistic structure of the canonical Western medical interview presupposes not the communicative contributions of family and companions but instead the participation of a single doctor and single patient.
From the view of anthropological linguistics, the medical interview, as a “communicative event” or “way of speaking” (Hymes 1972), exhibits specific communicative patterns and practices that govern the sociolinguistic roles of participants in clinical interactions . . . given its universal centrality to biomedical clinical encounters, what might the impact of the medical interview be on wellness-seekers, who may range from partially competent to entirely unfamiliar with its sociolinguistic patterns and practices? (Harvey 2008a:594)

Noting variations on this single doctor, single patient format in the centro de salud consultation (e.g., polyphonic responses), we can begin to examine the communicative contributions of Maya interactants in terms of the extent to which the medical interview as a speech event is or is not compatible with local indigenous interactional practices and strategies for obtaining information.

The frequency of Maya companion and coauthored (polyphonic) rather than individual patient responses to physician’s questions reflects different sociolinguistic expectations and presuppositions about what the role of participants and their communicative contributions as physicians, wellness seekers, and companions should be. But countering the variation observed in the ways in which Maya wellness seekers and their companions formulate responses is that they ask questions in a manner consistent with the sociolinguistic role of the canonical patient. That is to say, in the centro de salud consultation, as typical medical interviewees, the Maya wellness seeker and her companions ask very few questions and volunteer little information that is not specifically prompted by questions. This, however, is neither characteristic nor consistent with the sociolinguistic roles or communicative contributions of Maya healers, wellness seekers, and companions in intracultural therapeutic interactions.

With the centro de salud encounter as a point of comparison we now return to the analysis of the dispensario consultation and ask what the paucity of healer questions and the frequency of wellness seeker/companion-contributed illness narratives (largely unprompted by questions) tell us about the set of sociolinguistic relationships that Maya therapeutic interactions presuppose and what kind of communicative competence is both expected and required to properly participate in such interactions. The communicative contributions and interactions
of participants over the eighty-two bars of the *dispensario* score are such that one can say it does not contain a medical-interview equivalent that we could call a “therapeutic interview” between the healer, wellness seeker, and companion. Indeed, my ethnographic and linguistic research in Nima’ suggests that the interview as such is not a speech event in the local K’iche’ repertoire. Therefore, as a way of speaking, the medical interview is inconsistent with local communicative practices and ideas about how information (and especially information on wellness, illness, and care) should be elicited and narrated (see Harvey 2008a).

This linguistic anthropological observation, though not novel by any means, raises as many questions as it answers when specifically considered with respect to the communicative practices common to Maya intracultural therapeutic consultations (see Briggs 1986; Spradley 1979; Carbaugh 1990). If during Maya therapeutic consultations, information on wellness and illness is not primarily elicited through the healer’s use of questions and answers (i.e., an interview), then what are the appropriate ways of speaking and expressing that are called on for obtaining and giving such information? To be sure, for those of us who are either participants in or observers of the culture of biomedicine it seems only rational—and in fact “natural”—that health information should be elicited from patients through the use of questions. But this perspective, though possessing its own situational cultural legitimacy, can be scientifically burdensome if inadvertently carried over as an expectation or if used to ground an approach to understanding Maya therapeutic (nonbiomedical) interactions.

Indeed, the challenge that the *dispensario* consultation presents is how to formulate an anthropological linguistic analysis and discussion of Maya intracultural therapeutic interactions when they seem to lack many of the familiar guideposts (e.g., an abundance of question-and-answer sequences) around which our theories and methodologies for studying language use in health care were devised. Chapter 6 tackles this and other issues by offering an analysis of the K’iche’ communicative practices that, eschewing the conventional focus on the question-and-answer format, explores the cultural context of care and the manifold sociolinguistic factors governing Maya ways of speaking and expressing ideas about wellness, illness, and care in therapeutic interactions.
“ANSWERING” AS A WAY OF “ASKING” (ELICITING ILLNESS NARRATIVES)

Revisiting the polyphonic score of the dispensario consultation and the communicative contributions of the participants across the eighty-two bars suggests that information regarding the wellness seeker’s illness experience is not elicited (primarily) through the healer’s use of questions (see appendixes C and D). While interesting in and of itself, this observation gains new significance when we study the score and note that quantitatively, the wellness seeker speaks more frequently and for longer durations than any of the other participants in the dispensario consultation. As noted, this contrasts dramatically with the communicative practices and the quantity of speech used by the wellness seeker in the centro de salud consultation (see appendixes A and B). There are two rather obvious ways of approaching this variation. The first is to reduce the verbal activity of the dispensario (and the centro de salud) wellness seeker to phenomena explainable in terms of the idiosyncrasies of individual speakers (loquacious versus reticent). The second is to consider explanations for this variation that arise from implicating the cultural context of care and interrogating the interactions between the various participants in the encounter. This study pursues the latter approach.

What is the role of an ajkun in a Maya intracultural therapeutic consultation and are there recognizable communicative and interactional practices that accompany this role that, when enacted (lived), fulfill the therapeutic expectations of other cultural actors? Many years ago, in conducting a linguistic anthropological analysis of Maya therapeutic care among the Tzeltal-speaking Maya of Tenejapa in Chiapas, Mexico, Duane Metzger and Gerald Williams discovered that
during the course of the pulsing [diagnosing], the curer may carry on conversation with the family, the subject of conversation being unlimited, and the occasion not necessarily excluding jokes and laughter. If, during this conversation, the curer makes obvious attempts to elicit from the patient or the attending family the information which is properly forthcoming from pulsing, it is likely to be said that he is a /ʔihɛ’inal/ [“junior curer,” literally, “younger sibling curer”] and not a /b’ankilal/ [“master curer,” literally, “older brother curer”]. /te me ya sna’ ya? yel k’ab’ale ma ya shohk’o/ “If he knew how to pulse, he would not ask questions;’ he said.” (1963:223)

The links that Metzger and Williams observed nearly fifty years ago in Mexico between the culture of care and the communicative practices common to the roles of Maya healer, wellness seeker, and family both resemble and reveal much about the dispensario therapeutic interaction with which we are concerned here.

LOGOTHERAPY

As we have observed in the centro de salud encounter, in the description of the Tzeltal interaction, and in the dispensario consultation, Maya curative interactions are polyphonic, co-opting multiple voices and pluralistic experiences in their composition. As an ajkun, Miriam’s communicative practices, like those of Tzeltal curers, were informed by a culture of care that has ways of speaking and interacting both proper and foreign to it. Being a theurgical herbalist meant that Miriam could ask (without being regarded negatively) some illness-related questions of both the wellness seeker and her companion. She was not, however, expected to divine the source of the problem but rather to evoke supernatural or divine agency and involve it in the remedial action (see B. Tedlock 1992b; Hart 2008). To accomplish this, Miriam instructed the wellness seeker as to how she should pray, saying:

Qajawaxel Dios para que si katutzirik tambien y kata’ sachb’el amak la che re je la’ xab’ano pero chub’anik tu k’u la. (H:66)

(You need to make your prayers, you ask our supreme Lord
God in order for you to be healed. Also, you ask for forgiveness of your sins that you have committed but do not just make prayer to do it.)

The sociolinguistic expectations were that Miriam’s questions and communicative practices would contribute to a dialogic unfolding of the illness experience and ultimately to the emergence of a polyphonic retrospective diagnosis on which divine agency would take remedial action. Among K’iche’ peoples of Nima’ it may be said that if a healer knows how to facilitate healing she or he does not “get in the way” by asking too many questions or talking too much (see Samson 1983). A monologue—in the form of the dominance of the healer’s voice—where a dialogue is culturally appropriate would work to suppress participants’ contributions to the illness narrative, compromise the polyphonic diagnosis, and possibly jeopardize any supernatural restorative action. When the communicative practices of an ajkun in a Maya therapeutic consultation do not meet the sociolinguistic expectations of participants, the results (as other studies have noted) can be quite astonishing. The wellness seeker, companions, and family “may withhold information” from the healer altogether (Metzger and Williams 1963:223). I consider this issue further in chapter 7, but for now it will suffice to say that in cross-cultural biomedical encounters, interactionally prompting (albeit inadvertently) this cultural response can have negatives effects on the outcome of care.

Because the kinds of K’iche’ communicative practices observed in Maya therapeutic interactions emphasize co-opting the contributions of multiple voices and pluralistic experience in their composition, as speech events they resemble conversations (largely spontaneous dialogues) more than they do medical interviews (serial monologues) (see Pitarch 2010). Approaching the dispensario consultation as a dialogue enables us to formulate an analysis that explores the intricacies of sociolinguistic characteristics of Maya therapeutic interactions rather than focusing on less salient factors like question-and-answer sequences. To adequately consider the consultation as a kind of conversation (i.e., a dialogue) requires that we not only rethink the communicative contributions of participants but also their sociolinguistic roles.
Chapter 6

NARRATORS, CONNARRATORS, AND RESPONDENTS

Verbal interactions are inextricably linked to social structure (e.g., Sacks et al. 1974), and in dispensario consultations, seen as dialogue, we can detect the Maya sociolinguistic roles of narrator, connarrator and respondent(s) identified by Burns as interactive features common to the telling of Yucatec Maya narratives (Burns 1980). In K’iche’ Maya therapeutic interactions, storytelling and, more specifically, the retelling and “reexperiencing” of the illness narrative are the principal means by which information on wellness and illness is given out (see Jordan 1993). As I have noted in chapters 3 and 4 and expand on here, the narrator and connarrator(s) are the wellness seeker, family, and companion(s). The sociolinguistic role of the healer is to elicit the telling of the illness narrative and is primarily that of a narrative respondent. Here information is obtained and given not through the asking and answering of questions but rather through expertly facilitating and contributing to the unfolding of a polyphonic illness narrative and a (dialogic) retrospective diagnosis. With these observations in mind, we now examine an excerpt from the polyphonic score of the dispensario consultation and follow the interactions of participants across bars 1–12.

One of the first things we observe in the consultation, as already noted, is that Juana, the wellness seeker, speaks more frequently and for longer durations than her companion or the healer. This communicative practice is consistent with the Maya sociolinguistic role of narrator, observable in storytelling (Burns 1980:312) and here in the retelling of illness narratives. As illness narrator, Juana knows the story firsthand, having lived the experience, and she is (as the score shows) the principal contributor to its formation. Miriam’s initial question, “What is the essence of what your stomach is doing, and your head?,” is notably an open-ended and not a closed-ended “yes” or “no” question. This kind of question has the effect of giving the narrator (and connarrator) the communicative floor to begin retelling the illness narrative. Significantly, it bears mention here that the wellness seeker is an “interpretive/improvisatory narrator” (Burns 1980:312). That is, her account does not represent a well-rehearsed monologue. Instead it unfolds in an ongoing dialogue and is fleshed out or “given life” in interactions.

One of the numerous instances illustrating this point can be observed in bars 3–5. Here we see the development of the illness
Figura 13

Bar 1.
WS: Ah... porese le nijolom kaq'oxowik, le nijolom y le wanima' le...

C: Sux kub'ano le apam, le ajolom?

H: Mhm. Mhm.

Bar 2.
WS: E k'ut, kaqaj pa taq nuq'ab' k'I karakaratik are k'u la le nervio. Parece nervio k'u la karakaratik je kub'an le ri,

C: Y le kinb'ij in Juana... qas uwach.


Bar 3.
WS: Are je

C: K'o veces qas e chjaq'ab' e... kjumum, kjumum kel wa ti como ya k'u silenco chile chile k'ut. Je.

H: Mhm. Mhm.

Bar 4.
WS: A xa le q' aq', a xa le nervio kub'anowik Kinche

C: Are la' le nervio kub'anowik... com xa kula' la a choq'ab' man k'o.

H: Mhm.

Bar 5.
WS: A xa le nervio kub'anowik... com xa kula' la a choq'ab' man k'o.

C: Are la' le nervio kub'anowik... com xa kula' la a choq'ab' man k'o.

H: Mhm.

Bar 6.
WS: A xa le nervio kub'anowik... com xa kula' la a choq'ab' man k'o.

C: Are la' le nervio kub'anowik... com xa kula' la a choq'ab' man k'o.

H: Mhm.
Figure 14. polyphonic score

Bar 7.

WS:  Ah . . .  chi ri b'a la' y aj je k'ax le le nupalaj y kuna' ch nuwach ri' .  Kuna':

C:  

H:  

Bar 8.

WS:  k'o veces le nupalaj je k'o b'an ni kariparatik e le waral, le waral je kub'an le ri' kujik rib' .  Mhm.  Y chi k'ut

C:  

H:  

Bar 9.

WS:  kinb'ij le in k'ax kin'cak'ik kinch'a ri.  Kwaj in le, le, komo inyección le ri ek'ia kitijik

C:  k'o veces kuwar ta chaq'ab' ,

H:  Mhm.  

Bar 10.

WS:  Arese eu, we ma, pero we ma are le nervio, le are le

C:  kuwar ta, kuwar ta, k'o jun viaje kuwar ta chaq'ab' .  Man kuwar taj.

H:  Mhm.  

Bar 11.

WS:  le nujolom kq'oxowik, kq'axowik, kq'oxow nujolom.  Pero tz'are le waral le jere tzij ketijik Kinjo are k'u le nertigio:

C:  

H:  

Bar 12.

WS:  o mar e taj.  Arese, xawilo kus kja chik le nujolom.

C:  

H:  Areso, are k'u la le nervios.  Tonces, kuwar taj pa la Jolom.  Arese, kuwar taj pa la Jolom.
Bar 1.

WS: Uh... well, my head hurts with sustained pain, my head hurts and like my spirit.

C: What is the essence of what your stomach is doing, and your head?

H: They burn. And the nerves. Yes, they dropped to my feet and to my hands, burning like being next to fire and coming directly to my head.

Yes.

C: Yes.

H: Yes. Hmm. Yes, is that what she hears?

WS: Yes.

C: Yes.

H: Yes, hm. They are times at night... it hums. It hums and leaves this area as if there were no silence there.

WS: Yes. Right.

C: Yes.

H: It descends to my hands, constantly scratching. This is because of nerves. Then, it's nerves. This is the constant scratching it makes. Look.

Yes.

WS:

Yes.

C:

H: That's right.

WS: Only a fever, only nerves do this, I say.

Yes, yes.

C: Only a fever, only nerves do this, I say.

H: That's it, it's the nerves that do that... such is the case, only then is the strength / force that is.

WS: Yes.

C: Yes.

H: Yes. Hmm. Yes, is that what she hears?

WS: Yes.

C: Yes.

H: Yes, hm. What is the essence...? What is the essence? There are times that it hums in my ear and it rings.

WS: Yes. This is scratching my stomach.

C: And I say, Juana... what is the essence...?

H: Yes.

WS: Yes, hm. Is that what she hears?

C: Yes.

H: That's it, it's the nerves that do that... such is the case, only then is the strength / force that is.
Bar 7.

WS: Oh... here it is a lot, and much... Yes, my face hurts and feels painful here in front. It feels absent. Then, for this reason it does ring.

Bar 8.

WS: That's right because of nerves. Then, it throws itself towards the head. Oh... here it is a lot, and much... Yes, my face hurts and feels painful here in front. It feels absent. Then, for this reason it does ring.

Bar 9.

WS: I say that the pain has worsened. I tell you, I want like the, the, the injection for the tremendous pulling sensation. There are times that she does sleep. There was a time that she did not sleep at night. She does not sleep. That's right, if it is not, but it is not nerves, that thing.

Bar 10.

WS: That's right, if it has hurt my head. But this right here, truthfully, it feels like the pain had been eating me. Because of the nerves or.

Bar 11.

WS: That's right, it hurts my head. It has hurt my head. But this right here, truthfully, it feels like the pain had been eating me. Because of the nerves or.

Bar 12.

WS: That's right, because of nerves. Then, it throws itself towards the head. Because of the nerves or.

Bar 13.

WS: That's right, I saw it just separating / splitting my head. Oh... here it is a lot, and much... Yes, my face hurts and feels painful here in front. It feels absent. Then, for this reason it does ring.
narrative being prompted by the companion’s partial question to Juana, “Y le kinb’ij in Juana . . . qas uwach . . . ?” (C:4) (“And I say, Juana . . . what is the essence . . . ?”). Note that although Juana interrupts her companion’s question (C:4; WS:4), she does so reciprocally by creating a transitional “link” (West and Garcia 1988; Ainsworth-Vaughn 1992). That is, before changing the topic, Juana places at the beginning of her interjection a short summary of Lu’s’ interrupted utterance, reiterating “What is the essence . . . ?” before continuing on with her response. But what concerns us here is not the type of topic transition used as much as the cooperative “fleshing out” of the embodied illness narrative that occurs.

**MAYA MULTIVOICED ILLNESS NARRATIVES IN THERAPEUTIC INTERACTIONS**

As narrator and conarrator, Juana and Lu’s work together to greater and lesser degrees throughout the consultation. They both know the illness narrative, and their interactions suggest that they anticipate each other’s contributions to its formation. As we have seen, Lu’s’ question, though only partially formed, triggers Juana’s account: “E k’o veces kjumum pa nixkin y ktz’ininik” (WS:4) (“There are times that it hums in my ear and it rings”). Using another transitional link, “K’o veces” (“There are times”) (C:5), Lu’s adds information to the illness account, saying, “qas e chjaq’ab’ e . . . kjumum, kjumum kel wa ri como ya k’u silencio chila’ chi k’ut” (C:5) (“at night . . . it hums, it hums and leaves this area as if there were now silence there”). The details that Lu’s’ contribution adds to the illness narrative demonstrates not only that she knows the narrative but also that she is a *rach’il* (of Juana) and, as such, is acutely aware of and involved in the illness experience (see Harvey 2006b). In Maya therapeutic interactions, whether the narrator, conarrator, or respondent is amending, questioning, or interrupting the illness narrative, it all occurs without the slightest bit of irritation on the part of any of the interactants (for a North American Klikitat Sahaptin example of this interactional feature of narrative, see Jacobs 1959:268). This is perhaps attributable to Maya sociolinguistic expectations that therapeutic interactions are to be dialogues and likely attributable to Maya interactional strategies that “identify” with narrators by utilizing reciprocal topic transitions and links.⁵
Once the illness narrative is under way, Miriam begins engaging in communicative practices that are consistent with her role as healer and respondent. That is to say, she “knows how to answer” (Burns 1980:312) the narrator and conarrator’s illness narratives. The healer’s answers are not so much answers to questions or solutions to problems as they are affirmations of lived experience, questions seeking clarification, and expressions of interest and/or compassion.

For example, a survey of the entire dispensario score shows that Miriam frequently answers the wellness seeker and her companion’s illness narratives with affirmations saying, “Mhm” (H:3) (“Yes”), “Mh hm . . .” (H:2) (“Yes, hm . . .”), “Mhm. Je, pues” (H:41) (“Yes, of course”), “Areso” (H:47) (“For sure”), and “Chiri pues” (H:26) (“Here it is of course”). Affirmations are, in fact, by far the healer’s most frequent verbal contribution to the consultation, a practice consistent with the role of elicitor as answerer. In addition to this there are numerous examples of Miriam asking questions for clarification: “Je, kuta la are?” (H:5) (“Yes, is that what she hears?”), “Xatij kunab’al at?” (H:20) (“You drank the medicine?”), “Su uyab’ naj awal?” (H:21) (“What was the essence of your little boy’s illness?”), and “Inyección xa kojo’” (H:51) (“Was an injection administered?”). There are also various examples of Miriam showing interest in the illness experience and compassion for the sufferers: “Xutzirij taj” (H:24) (“It didn’t heal”), “Ah . . . xa jun q’ij’” (H:32) (“Oh . . . only a day”), “Are katajinik” (H:41) (“Those that you pick”), “Xatatab’ej ne ri” (H:50) (“You’re not sure you recall”), and “Kach’ob’ tu k’u la” (H:61) (“You did not understand it”). All of these examples represent Maya ajkun ways of speaking, sensing, and expressing ideas about wellness, illness, and care that facilitate an unfolding polyphonic illness narrative and a dialogic retrospective diagnosis.

Given the sociolinguistic roles of Maya healers and wellness seekers discussed in this chapter, what effects might the sociolinguistically dissimilar interactional models of biomedical consultations have on the outcome of cross-cultural care? Also, how do Maya wellness seekers who find themselves caught between the two experience and negotiate the differences? While chapter 7 explores these questions in depth, some initial insights can be gained by briefly returning to the commentaries of the wellness seeker that began chapter 5.
RETHINKING COMPLICATIONS IN MEDICAL COMMUNICATION

To conclude our examination of the dispensario consultation we return to the wellness seeker’s comments that opened the previous chapter in which she compares biomedical and therapeutic encounters. Her comments (see appendixes C and D for the full text) come after she has painfully explained to the healer the circumstance under which she came to take too much medication. Relating this experience, the wellness seeker recalls, “Inyección, e kyeb’ caja pastill xintijo’” (WS:51) (“An injection, and I took two boxes of pills”). As the narrative unfolds, the healer asks, “Y pa le centro salud xkita’ k’una chawe at che kawaj kkoj le inyección o xaq xuwi li . . . ?” (H:59–60) (“And at the centro de salud, someone asked you to see if you wanted them to administer an injection or did they just . . . ?”).

Juana explains, “Va ne la’ ketzijonik xa k’a are le in kinta ta mas le castill are bien xkicha lo. Xki xkkib’ij k’u la’ pero xaq je’e xaq kinche la como kinta taj” (WS:60–61) (“Well, they discussed it [the medicine] but still, I just did not understand much Spanish . . . not very well. They say, they said, it [the medicine] is fine but only that it is good, but because I didn’t understand”). To this disclosure, the healer answered, “You did not understand it,” affirming her support of the wellness seeker’s narrative and experience. When considering the retrospective diagnosis that emerged from dispensario consultation, the wellness seeker wondered aloud. Why had she taken too much medication, why had things gone so terribly wrong (the loss of her newborn child and her ensuing illness)? Her answer is typified in the quote that begins chapter 5, which leads us into the next chapter on curative disputes and cross-cultural conflicts in Nima’:

Man kinch’ob’ ta, qas tene’ le qe le in ktz kixtzijon pa qach’ab’al. E kincholo da’ qas kinb’ij tzij bien kinta como la’ le kinta’ ti in le castill. (WS:61–62)

(I didn’t understand [the medical advice], it’s not like it is with us, you all speak K’iche’. I can understand the story, I can say the truth and I understand it when it’s said [but] I don’t understand Spanish.)
Almost two decades before [Dr. John C. Cutler’s] involvement with the [“Tuskegee”] study in Alabama, the PHS [Public Health Service] put Cutler in charge of a two-year research project in Guatemala. This experiment in the global South, rather than the American South, differed from the study in Alabama in two majors ways: government doctors did infect people with syphilis (and gonorrhea and chancroid) and then did treat them with penicillin. (2011:9)
—Susan M. Reverby (2011)

A HISTORICAL PERSPECTIVE ON CLINICAL DISTRUST

At the time of the initial phase of this research (2000–2001), the Maya peoples with whom I lived and worked openly vocalized their misgivings about Western biomedicine and, as this chapter explores, expressed trepidation and leveled charges of maltreatment that were often based in both historical memory and lived experience. Over the intervening decade of follow-up research in rural highland Maya areas, I have witnessed a subtle change in attitudes toward Western biomedicine; tolerance (and in some areas acceptance) has slowly replaced the extremes of all-out-rejection and complete distrust described in this chapter. Yet the significance of these attitudes and experiences are, unfortunately, as relevant and meaningful today as when they were originally observed and recorded. The international disclosure in October 2010 that decades prior to the infamous “Tuskegee” medical experiments performed on African Americans in Alabama, a U.S.-led Public Health Service research project knowingly infected Guatemalans with syphilis will likely again sound a cautionary alarm that might rekindle the embers of disaffection toward state-sponsored biomedicine in Maya communities. The shame of government-sanctioned medical betrayal
in Guatemala exemplifies some of the experiences of Maya peoples, setting a somber tone for the chapter by historically contextualizing clinical distrust.

“SHE’S GOING TO DO IT!” (CLINICAL COERCION AND COMPLIANCE)

As we huddled, late into the night, around the blue light from the computer screen, my research assistants and I listened and relistened to each and every word, laugh, and cry. Through the recordings of curative encounters, we entered the participants’ world, felt with them, celebrated their triumphs and lamented their losses. Inching our way through the tapes we faithfully wrote down all that we heard, adding any experiential information from ethnographic observations that we could. As these biomedical and therapeutic scenes unfolded, like children we would try to change the outcome of the unpleasant parts of consultations by turning our heads away or by shutting the machine off all altogether. Finding ourselves caught up in what Coleridge might have called “a willing suspension of disbelief,” we not only transcribed what we heard, but in some instances inserted our voices among those of the participants. And as if they could hear us, we admonished them, advised them, and warned them of any impending danger that we foresaw.

Once when my research assistant Xuan and I were halfway through transcribing a centro de salud consultation, we heard the Spanish-speaking voice of a Ladina nurse on the tape telling a Maya youth, “También, le toca su vacuna” (N:13) (“Now, it’s your turn for a vaccination”) (see appendixes E and F). On hearing this, Xuan became infuriated, saying, “She’s going to do it!” His uncharacteristic anger surprised and troubled me. Why this response to the prospect of vaccination? Was it because Xuan felt sure the wellness seeker was going to be forced into it? I understood what he meant, but in spite of it I remained hopeful for a different clinical outcome, perhaps because I was not present when the particular consultation was recorded. I responded to his charge, saying, “Oh . . . maybe not, we don’t know what’s going to happen yet. Let’s see.”

As we anxiously advanced through the recording, word by word, the outcome of the consultation gradually began to take shape. The nurse told the young man, “Esa vacuna es contra el tétano yo no sé
si usted ha oído . . . esta enfermedad de que causa tétano. ¿Verdad?” (N:13–14) (“That vaccination guards against tetanus. I don’t know if you have heard . . . this illness causes tetanus, right?”). He responded, “Sí. Sí, porque me han vacunado desde mi niñez” (WS:14) (“Yes. Yes, because they have already vaccinated me from the time of my childhood”). With this, my research assistant looked at the computer screen as we wrote and praised the Nima’ youth for his courage, saying, “That’s right, you tell her.” Feeling encouraged by his enthusiasm, I added, “You see, maybe she’s not going to do it! It doesn’t always have to happen.”

The next utterance that slowly formed on the screen disabused us of our brief optimism. In the face of the youth’s clinical bravery, the nurse tested his resolve, saying, “Ah . . . sí” (N:14) (“Oh, really”). Then, as we listened further, silence filled the consultation room and was eventually followed by the sound of nervous laughter that seemed to replace the young man’s confidence. The nurse continued on, “¿O sea que sí tiene su tarjeta?” (N:14) (“That is, if you have your vaccination card?”). Taking off his headphones and throwing them on the table in disgust, Xuan shook his head and let go a sigh. Then, with his head in his hands he repeated, “I told you . . . I told you!” Seeing his frustration, I too took off my headphones, turned to him and said, “You know, we don’t have to finish this one right now. I think we should take a break and come back to it later.” Though visibly perturbed, Xuan insisted that we continue transcribing the consultation, and so we did.

The wellness seeker went on to explain to the nurse, “No tengo porque ya . . . pasó varios años” (WS:15) (“I don’t have it [the vaccination card] because now . . . many years have passed”). But before he could finish, the nurse interrupted him saying, “Yo se que . . . Oh . . . bueno” (N:15) (“I know that . . . Oh . . . all right”). Cautiously optimistic, once again I commented, “You see, Xuan, he told her, and they don’t always do it.” But as we listened and wrote on, the next few interactions confirmed Xuan’s worse suspicions and caused me to doubt my claim concerning the unpredictability of clinical outcomes. The nurse, as if ignoring what the young man had said about already being vaccinated, told him, “Entonces, le voy a poner una primera ahora contra el tétano porque usted está trabajando en el campo” (N:15–16) (“Well, now I’m going to administer the first [vaccination] against tetanus because you are working in the fields”). “Sí” (WS:16) (“Yes”), the young man responded.
But which part(s) of the nurse’s declarative statement was the wellness seeker’s response of yes affirming? Yes that he agreed to be vaccinated or yes that he did indeed work in the fields? (see bar 6 of appendixes E and F). Whether the wellness seeker intended to agree with one or both of the propositions, the nurse took his response of yes to be his verbal consent to vaccination. Was the Maya youth ever directly asked by the health practitioner if he wanted to be vaccinated? Unfortunately, the answer is no. A close examination of bar 16 of the postconsultation reveals that the nurse combined her declaration of intent to vaccinate the wellness seeker with some accurate information about his occupation (N:15–16). Interactionally, this strategy of appending social information (i.e., “because you are working in the fields”) to medical declarations (observable throughout the consultation) worked to encourage an affirmative response to the nurse’s statement. The wellness seeker responded yes, as he did, in point of fact, work in the fields. But was he agreeing to be vaccinated?

FOR THEIR OWN GOOD? (COERCIVE TAG QUESTIONS IN CLINICAL CARE)

Clinical experience—that opening up of the concrete individual, for the first time in Western history, to the language of rationality, that major event in the relationship of man to himself and language to things—was soon taken as a simple, unconceptualized confrontation of a gaze and a face, or a glance and a silent body; a sort of contact prior to all discourse, free of the burdens of language, by which two living individuals are “trapped” in a common, but non-reciprocal situation.

—Michel Foucault, Birth of the Clinic (1973)

As we listened on, in vain my research assistant interjected, as if watching a horror movie, “Tell her that you don’t want it!” The nurse continued, saying, “Pues, si se lastiman o avaces hay alguna herida. ¿Verdad?” (N:16) (“Of course, if you get hurt or like sometimes there are cuts, right?”). When the wellness seeker again responded “Sí” (WS:16) (“Yes”), I looked at Xuan and regretfully conceded, “You’re right, he has no other choice, she’s going to do it.” Again, the nurse’s assertion that “if you get hurt or like sometimes there are cuts” is an accurate account of what could happen when working in the fields. After making the statement, however, she seeks and secures verbal agreement from the wellness seeker
by following it up with the tag question, “Right?” Pragmatically asking “right?” at the end of an utterance (in addition to being a closed-ended yes/no question) presupposes a response that affirms rather than negates the question. Given this, it is not surprising that the wellness seeker responds yes. But again, with what exactly was he agreeing? As we slowly pieced together the ensuing interactions, which were primarily composed of the nurse’s explanation of the need for vaccination (N:16–18), Xuan commented contempt, saying, “Son mentiras” (“They are lies!”).2

After interactionally encouraging the wellness seeker to agree with all of her sociomedical explanations but (notably) without ever asking him directly if he agreed to be vaccinated, the nurse announced, “Tonces, yo le voy a poner su primera vacuna y aparte le voy a poner la primera inyección para quitar un poco, y salu . . .” (WS:18–19) (“Well, I am going to administer your first vaccination, and aside from that I’m going to administer your first injection to remove a little, and healthy . . .”). As Xuan and I typed these words we became caught up in a futile attempt to change the consultation’s outcome with our will and words. Xuan warned, “Don’t let her do it!” Echoing his sentiment, I said, “Leave!,” not because I disagreed with the vaccination per se but because he had not been given a choice.

Before the nurse had finished explaining the vaccination, the young man interrupted her asking, “¿Dónde me van a poner la vacuna, disculpe? ¿En el brazo?” (WS:19) (“Excuse me, where are you all going to put the vaccination? In my arm?”). With this, any hopes that Xuan and I may have had about the outcome of the consultation were dissolved. Asking where he would be vaccinated implied his consent. In this ethnographic transcription session, we had been witness to yet another instance of a Maya wellness seeker being vaccinated without ever being asked directly if he wanted to be. We were saddened and frustrated, not because he was vaccinated, but because he, like so many others we knew of, was not given a discernible choice to accept or refuse the injection.

**MAYA WELLNESS SEEKERS IN DISPUTED FIELDS OF CARE**

In Nima’ perhaps no other practice was more emblematic of the larger sociocultural disputes between biomedical and therapeutic care and the wellness seekers who were caught between the two than that of
vaccinations. Here, by examining some well intentioned *centro de salud* practices such as vaccination campaigns we explore: a) controversies surrounding what many in Nima’ residents saw as biomedicine’s “incursion” into sacred areas of Maya therapeutic healing in the search of “patients”; b) some of the ensuing conflicts that have arisen; and c) some of the ways in which K’iche’ wellness seekers and patients are navigating these disputed curative domains. In addition to examining Maya views of biomedical practices in curative conflicts, I also explore health practitioner views of Maya therapeutic practices and discuss how the views on each side inform certain behaviors and customs that contribute to curative conflicts and mutual misunderstandings.

In examining appendixes E and F, one of the first things that we notice about the *centro de salud* consultation that opens this chapter is that its sociolinguistic composition varies greatly from other biomedical and therapeutic consultations that we have examined in this study. The cross-cultural biomedical interaction between the nurse and the young man is an example of what the *centro de salud* calls a postconsultation. Organizationally, it directly follows the primary consultation with the physician and occurs between a nurse, the patient, and her or his family and companions. According to *centro de salud* practitioners, there are multiple purposes for the postconsultation. Most significantly, it frees the physician from having to spend time offering patients detailed explanations of treatment plans and medication regimens by placing these responsibilities in the hands of the certified and auxiliary nurses, giving the physician time to examine more patients. Thus, at the *centro de salud*, it is the nurses who explain the treatment and administer medication. Postconsultations are designed to offer patients the opportunity to ask any questions they might have concerning their diagnosis and to make decisions about treatment.

It bears mentioning that the consultation between the nurse and the young man is particularly unusual in two respects. First, it illustrates an organizational mishap on the part of the *centro de salud* in that it is a postconsultation where the wellness seeker manages not only to receive a preconsultation but also a primary consultation *without* complying with the clinic’s requirement that he either show proof of vaccination or be vaccinated in the preconsultation stage. Second, in terms of its makeup, the encounter shows a single Maya patient, a young man
of fifteen, without any family or *achi’lab’* present during the *centro de salud* consultation. Both the organizational structure of biomedical consultations as well as their sociolinguistic dynamics greatly affect practitioner-patient interactions.

**DELETERIOUS EFFECTS OF MONOLOGUES ON MEDICAL INTERACTIONS**

Given that the postconsultation is supposed to be an opportunity for patients to ask questions, it is particularly interesting that when we examine the score we find that the wellness seeker says very little and asks only two questions: “Excuse me, where are you all going to put the vaccine? In my arm?” Indeed, a review of the score shows that there is very little if anything here that we might call a dialogue or dialogic interaction. Instead, the communicative scene of this postconsultation is composed of serial monologues made by the nurse, which are sprinkled with the occasional and frequently prompted (and/or coerced) affirmations of the wellness seeker. The characteristic Maya consultation is, as we have seen, sociolinguistically composed of multiple voices and pluralistic experiences; this consultation does not take such a form and thus contrasts sharply with the others that we have examined, being what might be called an archetypical monologic medical interaction in which health practitioners do nearly all of the speaking and are rarely spoken to (beyond receiving the responses that they themselves have prompted).

Given, as we discovered in chapter 6, that Maya sociolinguistic expectations are that in curative encounters practitioners will neither talk a great deal nor ask a lot of questions, then might we suppose that the reticence of the wellness seeker could be a culturally appropriate communicative response? That is to say, the wellness seeker’s reticence may indicate that he is “withholding information,” which is the culturally appropriate response to a practitioner’s monologue when a dialogue (at least from the Maya view) is sociolinguistically appropriate. Similarly, it might also be suggested that because the wellness seeker came into the clinical consultation as an individual (i.e., without the customary *achi’lab*) he assumed the full personhood of the patient (see Harvey 2008b). The nurse, understanding him as such, treated him according to biomedical sociolinguistic expectations of what the communicative and comportment practices of a patient should be.
These explanations aside, what are the implications of this largely monologic participatory structure when we consider that at the *centro de salud*, the postconsultation is the communicative scene where all medical treatment and decision making occurs? What type of sociolinguistic interactional structure might we expect to see in a communicative scene where decisions are supposed to be made by patients and/or negotiated with practitioners? In the nurse’s monologues and the patient’s scattered affirmations of them, the score depicts an interaction that is not merely guided but orchestrated by a single domineering voice. Close examination of the contents of the communicative contributions of the participants in the consultation reveals that there are no decisions to be made about treatment or anything else. The nurse’s questions and declarations do not allow for choice or negotiation; they merely request affirmation, creating only the appearance of a dialogue with the use of tag questions (see, for example, N:3, N:5, N:11, N:12, N:14, N:18, N:21).

Conventional linguistic descriptions suggest that tag questions are primarily an informal conversational device (e.g., Brown 1981), but many of the discourse functions of tag questions that are observable in informal conversation are visible here in a formal medical interaction. That is, they function to “check inference, seek agreement, and invite confirmation” (Brown 1981). Unlike in informal conversations, however, the effect of these kinds of question structures on the medical interaction is to provide the patient with little to no interactional choice except to agree with the declarations (diagnosis) and treatments that are offered.

The monologic character of *centro de salud* postconsultations that I observed did not go unnoticed by those Maya wellness seekers who experienced such interactions firsthand. Indeed, it was my research assistant’s own experiences within such medical encounters coupled with his listening to and helping to transcribe numerous consultations during our work together that were the source of the anger and frustration I described earlier. The significance of such interactional practices in clinical encounters cannot be overstated, as we are not discussing dehumanized practitioner-patient discourse that is somehow detached from the larger issues and implications of human suffering and care for the sick. In both biomedical and therapeutic interactions, communicative practices are coupled with and related to remedial actions. In both
biomedical and therapeutic consultations that Maya wellness seekers participate in, remedial actions can sometimes be highly controversial and contested, despite the best intentions of all involved.

“NO VACCINATION, NO CONSULTATION” (CLINICAL CONFRONTATIONS)

Shortly after I began research at the centro de salud in Nima’, I noted that a great deal of time, talk and resources were being devoted to vaccinations. It was the often-recited rule at the centro de salud that no one (including children) could receive a primary consultation with the physician unless she or he was in possession of a vaccination card. In practice, however, this rule was not as inflexible as it was outwardly intended to appear to Nima’ residents. In cases of serious illness the physician would not turn patients away but instead would see them outside of his consultation room. By moving to another part of the building (out of the view of waiting patients), he could maintain the appearance of the “no consultation without vaccination” rule. Despite these humane provisions, great emphasis was placed on vaccination cards. These clinic-issued cards contained basic information about patients; that is, their name, date of birth, sex, and most significantly, practitioner-initialed dates indicating when and what specific vaccination(s) the card carrier had received.

The idea of mandating that one have in her or his possession a vaccination card during all visits to the centro de salud seems fairly straightforward; however, in practice this medical mandate presented a certain set of unintended problems and clinical complications in Nima’ and in other Maya towns and villages. While in cities and metropolitan areas throughout Guatemala residents were in the practice of always carrying their cedulas (national identification cards) as proper citizens, in the rural towns and villages many people did not carry papeles (papers) unless they intended to leave these areas.

There is an entire culture of paperwork and documentation that grows up around literacy and school attendance that is only now beginning to emerge in Guatemala and has not yet taken hold in rural agricultural areas like Nima’. It is not surprising, then, that Maya wellness seekers in Nima’ infrequently brought their vaccination cards to centro de salud consultations. In fact, in my follow-up interactions with them,
most indicated that they had misplaced their cards somewhere at home or lost them altogether.

The consequence of having a medical system based in a rural area that not only presupposes but demands that all wellness seekers possess this cultural level of literacy (i.e., in the managing of vaccination cards) is that those who seek treatment and who are not seriously ill are offered a very difficult choice. The choice, at the time of this study, was to be vaccinated or not receive a medical consultation with the centro de salud doctor. In setting the scene for this choice within the wider cultural context and organizational structure of the clinic it is important to note that receptionists did not check to verify that all clinic visitors possessed vaccination cards at the initial point of clinical contact, at the check-in stage. Rather, it was after wellness seekers had been registered, had listened to promotional talks relating to health, and had waited for their names to be called for preconsultations (which could take anywhere from 1 1/2 to 4 hours) that proof of vaccination was requested. A consideration in the decision to be vaccinated in the preconsultation was, therefore, the fact that the wellness seeker had already waited for several hours to see the physician.

I have up until now discussed this choice to be vaccinated primarily from the view of the centro de salud health practitioners, but what about wellness seekers? Indeed, even describing this as a choice between being vaccinated or not receiving a physician consultation is perhaps a little misleading in that it assumes that wellness seekers have not already been vaccinated. The position of the nurses who administered the vaccinations was simply that those who didn’t have vaccination cards must not have been vaccinated. Furthermore, as the score and description of the postconsultation between the nurse and young man illustrate, when Maya wellness seekers state that they have already been vaccinated or that they have left their card at home or misplaced it, health practitioners most often conclude that they are lying and that they merely do not want to be vaccinated. However, for many of the Maya wellness seekers (about 45 percent of those with whom I was present during their preconsultations) the choice was not between being vaccinated or not but instead between being revaccinated or returning home without having been seen by the physician.
Being present as a scientific observer during many preconsultations meant that I kept track of many of those who were vaccinated as well as the vaccines that they were given, a process that was aided by the fact that I knew many of the wellness seekers personally from relationships formed outside of the clinic. In addition, I had taken notes on the contents of preconsultations during and after health care visits. When confronted with the choice of either returning home without having seen the doctor or submitting their child to revaccination in order to see the doctor, many Maya women who had already had their children vaccinated but who did not have their cards to verify it choose revaccination. Discussing this choice with Nima’ women who I knew had been coerced into making it revealed that it was a difficult moment fraught with frustration and born of the desperation of mothers trying their best to secure care for their sick children.

My acquaintance with many of these women outside of the centro de salud, who had generously agreed to participate in my investigation, complicated both my research and my social relationship with them. They were not strangers but rather the grandmothers, mothers, aunts, sisters, and daughters who had welcomed me into their homes; we had eaten and drank together, shared laughter and sadness, and they had patiently given of their time to teach me Nima’ K’iche’. These relationships encouraged me to step back from the centro de salud and question with Maya wellness seekers why it was necessary that they be personally responsible for their vaccination cards. Why did the centro de salud that produced and required vaccination cards not keep written records of all of those who were vaccinated and with which vaccines? It would seem that the ability to check such records could prevent the problem of revaccinating patients with the same vaccines. What, if anything, was there to be gained or put at risk by revaccinating patients?

The centro de salud did, in fact, keep written (though not computerized) records of all vaccinations. They were required to do so by health care officials at the Ministerio de salud pública y asistencia social (Ministry of Public Health and Social Assistance) in Guatemala City. However, these records were primarily utilized in quantitative studies charting progress in local and national vaccination coverage. These records were not generally used to verify whether or not an individual patient had been
vaccinated. Disturbingly, there were Maya wellness seekers in Nima’ who had been vaccinated up to four times with the same vaccine because of the centro de salud’s “no vaccination, no consultation” policy.

There were also local rumors surrounding the centro de salud's alleged unequal treatment of some wellness seekers in this respect. Preconsultations, like postconsultations, were generally conducted by a nurse with the wellness seeker and her or his family and companions. On occasions when the centro de salud was particularly busy, it was not uncommon for a nurse to usher a new wellness-seeker group into the preconsultation room before the previous wellness-seeker group had left. Once while sitting in a preconsultation with a Maya woman whose child had just been revaccinated, a Ladina woman entered with her teenage daughter. The pair had traveled to the centro de salud from their home about an hour west of Nima’. As one of the nurses explained dosage and medication regimen to the Maya mother, another nurse began by asking the Ladina mother, “¿Usted tiene la tarjeta de vacuna?” (“Do you have the vaccination card?”). The Ladina mother replied, “Fíjase, no la tengo, imaginase, dejó en la casa” (“Look at this, I don't have it. Imagine, I left it at home”).

The nurse explained to her, as she had done to the Maya woman, that all patients must have their vaccination cards or they are not able to see the physician. The Ladina woman apologized, explaining that she had been rushing before leaving home and she assured the nurse that her daughter’s card was in fact at home. When the nurse again responded, “No vaccination card, no consultation,” the Ladina woman turned to her daughter and in a low voice asked if she would agree to be vaccinated. The teenager would not. The nurse then suggested that they go home and bring back the card. Interestingly, this was an option that I had not observed being offered to Maya wellness seekers, who it would seem could more feasibly go home and bring their vaccination cards back because they often lived much closer to the centro de salud. Offering the Ladina family the option of returning home to retrieve their card also suggested that the nurse believed, unlike in the Maya case, that the Ladino family did in fact have a vaccination card (see Johnson et al. 2004b; Asch et al. 2006).

At this point, the Ladina mother asked if she could speak with the doctor. She and her daughter left the preconsultation room and stood
outside of the doctor’s office waiting to speak with him when he opened
the door to call out the next patient’s name. The Ladina mother and
daughter did, in fact, receive a consultation without being vaccinated
or revaccinated (whichever the case may have been). It is possible that
instances such as these have contributed to local K’iche’ impressions
that Ladino and Maya patients do not receive equal treatment.

MIXED PERCEPTIONS OF MEDICAL PLURALISM AND
THERAPEUTIC CHOICE

Maya wellness seekers negotiated the issue of vaccination and revacci-
cination at the centro de salud in a number a ways. It bears mentioning
again that with the wide variety of Maya therapeutic options available
in Nima’, centro de salud care (while playing a significant role) remained
for many residents at the time of this study as a kind of “alternative
medicine” (Harvey 2011). Some Maya wellness seekers who had had
particularly negative experiences related to vaccinations and/or those
experiencing clinical complications relating to other cultural conflicts
simply chose to avoid the centro de salud entirely. The persistence of
“traditional” Maya beliefs with regard to spirituality and health in this
general geographic area are well documented (see Hart 2008). Not sur-
prisingly, a nearby town recently received an unflattering depiction in a
missionary’s travelogue:

As we stood watching the devotees of San Simón, we felt
smothered by the intense demonic presence that filled the
room. Provoked by all I had seen and grieved in my heart,
I determined something must be done. The people must
know the truth. I must preach the gospel to the people of
this dark city. Only later did we learn that the last missionar-
ies attempting to preach in this village had been run out of
town with stones. (Griner 2005:24)

Older townspeople and local adherents of Maya spiritual and reli-
gious practices made up the largest percentage of Nima’ residents who
did not regularly attend the centro de salud (see Warren 1978). For these
wellness seekers, Maya ajq’ijab’, ch’obonelab’, ajkun, and aipab’aqab’
were the therapeutic practitioners of choice. From these healers would
come the first and last word in wellness, illness, and care (Cosminsky
and Scrimshaw 1980; De Valverde 1989; Hinojosa 2002; Hart 2008). That is to say, on the infrequent occasions that these residents sought medical treatment at the *centro de salud*, it was always after Maya therapeutic remedial action had already been taken. Similarly, biomedical treatment was almost never (willingly) the last treatment sought, as these residents would follow up biomedical treatment with more Maya therapeutic treatment (see Low 1988).

Practitioners at *entros de salud* in nearby towns were well aware of indigenous residents’ enduring loyalty to their Maya therapeutic healers. In fact, in a hundred-page report entitled *Diagnóstico integral municipal Zunil* (*Integral Diagnostics of the Municipality of Zunil*), which covered a period from 1996 to 2000, government researchers in cooperation with health care practitioners made numerous references to the problems caused by the sick of Zunil (a town near Nima’) consulting “quack” healers (UTP 2000). In discussing the challenges to health care that they regarded as an outgrowth of residents’ basic lack of health care knowledge, health researchers and practitioners offered the following observations.

Nuevamente tomamos como factor determinante los cambios de clima que se manifiestan en esta región y también la falta de conocimiento de las madres al respecto ya que a veces confunden un malestar gripal, con una sintomatología que se convierte en mortal si en pocas horas no se le prestan las atenciones debidas e inmediatas, buscando la asistencia medica profesional (hospital regional de occidente, Rodolfo Robles, hospitales privados) y no ir en busca de curanderos que con “aguitas de hiervas u otros,” intentan salvar la vida de un niño afectado por la bronconeumonía. (UTP 2000:66, emphasis in the original)

(We again took note of the decisive factors like the changes in climate in this region and also the lack of knowledge on the part of mothers with regard to [the fact that] they sometimes confuse the uneasiness of a cold with the symptoms that become deadly in a few hours if they are not given immediate attention. These [conditions] require looking for the assistance of a medical professional (western regional hospital,
Rodolfo Robles, private hospitals) and not going to search for [quack] healers, who with “little herbal waters or others,” try to save the life of a child affected by bronchopneumonia.)

Here, we are not so much concerned with whether or not these observations represent accurate assessments of Maya wellness seekers’ knowledge of illness or of the curative ability of Maya healers but rather with what such claims reveal about health practitioners’ perceptions of Maya ideas and practices concerning wellness, illness, and care. From the view of health practitioners the only appropriate place to seek health care (and to receive “immediate attention”) is in clinics and hospitals. Only these sites are presumed to provide the services of medical “professionals.” Likewise, there is a clear derision of both Maya therapeutic healers, who are described as “quacks,” and their remedies, which are characterized as “little herbal waters or others” (see Nigh 2002; Harvey 2011). In sum, the excerpt expresses health practitioners’ suspicions, at the time of the study, about Maya health-related decision making and their doubts about the effectiveness of Maya therapeutic care.

But suspicions about health care decision making and doubts about remedial action were not limited to health researchers and practitioners; local Maya wellness seekers expressed their uncertainties as well. One night over dinner some of my neighbors in Nima’ recounted an illness narrative that told of how their daughter had taken their grandchild to see the centro de salud physician because of a nagging cough and chest cold. When their daughter did not bring her child’s vaccination card, the nurse reportedly revaccinated the child without the mother’s approval. That night, to the surprise of the parents, the child became gravely ill with what they described as q’aq’. With their eight-month-old baby near death, the parents and grandparents rushed out into the night across the town to the house of a trusted Maya ajkun whose chak in their view saved the child. The family and healer’s retrospective diagnosis revealed that the child had nearly died because she had been administered “ek’ia kunab’al” (“too much medicine”) and “ek’ia b’aq” (“too many vaccinations”). The family vowed never to return to the centro de salud and discouraged others from doing so.

On the rare occasions when such local accounts made their way to the practitioners at the centro de salud, these claims of poor treatment
were refuted by suggesting, as the report did, that instances of medical complications were caused by Maya peoples’ own insistence on

creyendo los curables con la utilización de “aguitas” o remedios caseros como también les llaman y la poca importancia que le prestan a los productos medicos existentes en las farmacias de ésta comunidad. (UTP 2000:72)

(believing that [illnesses are] curable with the use of “little herbal waters” or homemade remedies as well as by them giving little importance to the existing medical products in the pharmacies of the community.)

A common explanation that health practitioners offered to challenge local claims about negative experiences after receiving vaccinations or taking medications was that the patients themselves were negligent because they went to a “quack” healer first, only going to the centro de salud or a hospital when their illnesses were already in advanced stages and sometimes untreatable (see Briggs and Mantini-Briggs 2003). The health practitioners also expressed perplexity over why the sick of Nima’ did not simply make use of the town’s biomedical pharmacy.

While residents did make use of small Nima’ pharmacies in family stores, they patronized the biomedical pharmacy less frequently because of its direct association with the centro de salud (see Vinay and Nichter 1998). Furthermore, certain medications at the biomedical pharmacy required that patrons have written prescription slips from the doctor. These slips could only be attained if the wellness seeker underwent a primary consultation, as well as pre- and postconsultations, during which vaccinations were frequently administered. Maya wellness seekers frequented non-centro de salud–associated pharmacies because in these establishments, over the counter advice sufficed to obtain any medication (Harvey 2011). As noted in chapter 5, this was a factor distinguishing Maya participation in therapeutic care from their involvement in biomedical care.

NEGOTIATING REVACCINATION

Despite the circulation of stories like those of my neighbors that disparaged the centro de salud and its practices, there were Nima’ residents
who frequently visited the clinic. Like their “noncompliant” Maya counterparts, the adherents also had a difficult time keeping track of their vaccination cards. Several local strategies emerged for dealing with the dreaded problem of misplaced cards and revaccination, one of which was the practice of misinforming centro de salud practitioners about the age of their children. Because their children had already been vaccinated (a fact I confirmed), these mothers knew at precisely at what age their children were scheduled to receive each vaccination. They would simply tell the nurses that their children were too young to receive a particular vaccination, adding that in so many weeks or months they would be old enough to do so. These same mothers, when they did remember to bring their vaccine cards to subsequent consultations, would have their children vaccinated according to the sequence that their cards indicated. This strategy worked on some occasions, but more often than not the nurses would simply revaccinate these children with the appropriate dose of the vaccination for the age that the parents claimed the children to be.

Complicating the issue of the age of children as it related to centro de salud practitioners’ administering of vaccinations (and medication) was a seemingly unrelated legal mandate from the Nima’ municipal government. This mandate stated that all children born in Nima’ must be registered with the local government within two months of their birth or their parents would be penalized by fine. The form that parents were required to fill out had blank spaces for their names, the name of the child, the sex of the child, the date of birth, and the sector of Nima’ where the parents resided.

Again, the culture of literacy and paperwork competed and conflicted with local Maya sociocultural practices. In Nima’ Maya parents frequently did not settle on a name for their children until they were several months old (usually between about five and nine months of age). While there may have been some parents in the outlying areas of Nima’ who did not register their children at all, it was more frequently the case that parents would wait until their child had been given a name and only then register him or her with the municipality, adjusting the child’s age accordingly in order to avoid paying a costly fine.

It was not uncommon for Nima’ babies to go through several names before the appropriate name was discovered, a name that would, as the
locals put it, “sit well with them.” As such, from time to time names were a source of confusion at the centro de salud. Families would check in at the clinic and indicate that their child had one name, and then in the pre-consultation it would emerge that their vaccination cards had a different name. It is not difficult to imagine how such a practice might have been perceived cross-culturally at the centro de salud as an attempt by Maya parents to use the vaccination card of another child (with a like surname) so as to avoid vaccination. However, I am not aware of any instances of such deception. Further complications could arise when new vaccination cards were issued with current names while older cards bearing previous names were still in circulation (though temporarily misplaced).

It was a K’iche’ Maya family visiting Nima’ from their home in Santa Lucia de la Reforma who helped me to better understand the cultural context of this practice. They recounted the story of how they had initially given their child a name and how he had taken sick shortly thereafter. It was only after they had talked to a nim winaq (a great or aged person) that they discovered that the name might have been the cause of the illness. They immediately decided to change the child’s name to that of their local Maya Catholic priest (who was at the time of my research the current Catholic priest for Nima’). When they first uttered the baby’s new name, Geronimo, the parents recalled that the eyes of their little boy lit up and a smile filled his face. In their estimation, from that moment onward he had been generally healthy. This story helps us to link and understand the nexus of three would-be unrelated cultural practices that converge in cross-cultural clinical care: Maya cultural practices of naming and renaming and their relationship to ideas about the wellness of children, the municipality’s practice of mandating that newly born children be registered at a certain time and its relationship to the decisions that Maya residents make about the information that they report, and the centro de salud’s practice of relying more on written documentation than on patients’ verbal accounts for vaccinations when prescribing treatment and its relationship to and influence on remedial action. Returning to the issue of negotiating clinical care, another strategy used by Nima’ wellness seekers to avoid revaccination involved (in an unlikely way) my being present with them over the course of several of their preconsultations. Because I knew some of the women who visited the centro de salud, when we saw each other there
we would on occasion make small talk while the attending nurse was busy writing down information about height, weight, blood pressure, and so forth. On one such occasion, the mother of a close companion of mine had forgotten to bring her child’s vaccination card. She had come to the clinic because the physician had requested the week before that she return so that he could check on the condition of her child, who had a chest cold. She explained to the nurse, as others had done that day, that her child had already been vaccinated the week before. The nurse reprimanded the mother, telling her that she would have to learn to be responsible, that she had been to the centro de salud often enough to know the rule: “No vaccination card, no consultation.”

Hearing this, the wellness seeker turned to her two companions and whispered in K’iche’. They would have to make a decision. I was not able to understand all that was said, but I perceived what the K’iche’ peoples of Nima’ might have called the eloquence of Maria’s eyes, and they seemed to speak of frustration and sadness. It was not considered good for her to be burdened with such strong emotional impressions; I had been told of the potential dangers of this by townspeople on numerous occasions. She was pregnant, and the common belief was that the baby within her would no doubt sense these disruptive feelings and might be harmed. I searched for something to say, a way to lighten the weight of the moment and mood as I had seen others in Nima’ do in similar circumstances. “Thank you for the pears, they were the sweetest that I’ve ever had!”, I awkwardly blurted out to Maria in Spanish.

With my comment, the nurse looked up from her writing and said, “Yes, thank you doña Maria, they were very good.” The nurse, in saying this, perhaps to her own surprise, recalled that doña Maria had handed us four golden pears in the previous week before she left the preconsultation room. Maria had given those pears as a token of her appreciation for the care that the nurse had taken when vaccinating her little girl. As if thinking out loud, the nurse asked, “Your child was vaccinated last week, right?” “Yes,” Maria anxiously responded, as the nurse added, “That’s fine!” Seeing the smiles fill the faces of Maria and her companions indicated that the dreadful impressions of fear had been held off, and it helped me to understand what had happened quite by accident.

Though it was never my intention to cause any disruption during the curative interactions at the centro de salud, over time my presence there
and my knowledge of some of the wellness seekers personally did, nevertheless, influence the interactions. When wellness seekers were faced with the difficult decision of whether to be revaccinated because they did not bring their cards, my mention of some unique aspect of the previous preconsultation when they were initially vaccinated could prompt the nurse’s recollection of the initial vaccinations or cause the nurse to consult the records to verify whether or not a particular patient had in fact already been vaccinated or not. Another change in administering revaccinations that arose over time and that may have also resulted from my presence at the centro de salud was the slow increase in the frequency with which Maya wellness seekers without vaccination cards were offered the option of going home to retrieve their cards instead of having to choose between (re)vaccination or no physician consultation.

However, strategies employed by Maya wellness seekers to avoid vaccinations were not always motivated by the fact that they had already been vaccinated or that they had left their cards home or misplaced them. There were specific occasions when Maya wellness seekers who did remember to bring their vaccination cards did not want to be vaccinated. In such instances, Nima’ women who brought their incomplete vaccination cards to the centro de salud would indicate that they did not want themselves or their children to be vaccinated. Follow-up ethnographic interactions with these wellness seekers revealed that on many of these occasions they had made prior arrangements with their families andcompanions to bathe in community baths. For the medically “compliant” in Nima’, being vaccinated on the same day that one had planned to bathe was avoided if at all possible. The widespread belief was that while immersed in the hot baths that sprang from the surrounding volcanic mountains, illness could and did frequently enter into the body through the hole in the skin made by the b’aq (bone or needle) (consult M. Douglas 1960; B. Douglas 1969). Being vaccinated and bathing on the same day was understood to be reckless and an invitation to illness.8

Though health practitioners were not aware of how this specific set of ideas about hot baths, vaccines, and illness susceptibility influenced the behaviors and practices of the Maya who visited the centro de salud, had they known, it is reasonable to suspect that they would have reacted the same way they did to other indigenous ideas about wellness,
illness, and care. On the topic of Maya ideas about hot baths and wellness, health researchers and practitioners in the nearby area made the following observations:

Al entrevistar a algunos vecinos de sector indicaron en términos utilizados por ellos (que dejan que fluya el catarro, porque así se liberan de este malestar y es bueno) llegándose a casos extremos de no diferenciar una gripe de una bronconeumonía (siendo los daños más graves e irreversibles) indicando también que según sus antepasados exponerse al ambiente frío luego de un baño de agua caliente, lo hace Mas Fuerte para la Agricultura que a toda luz es ilógico e inaceptable por razones de que las defensas del organismo se van deteriorando a causa de dichos descuidos, y que los cambios bruscos que el organismo percibe al salir de un baño de agua caliente o de vapor. (UTP 2000: 64–65)

(On interviewing some neighbors of this sector, they indicated in terms used by them [that they allow the phlegm to flow, because they are freed from its uneasiness and it is good], bringing them to the extreme cases of not differentiating between a cold and bronchopneumonia ([the latter] being the more serious and whose damage is great and irreversible]. They also indicated that according to their ancestors, to be exposed to the cold atmosphere after a bath with hot water makes one Stronger for Agriculture. This is illogical to all rationality and unacceptable for reasons that the defenses of an organism become deteriorated due to this negligence and the abrupt changes that the organism perceives on leaving a hot water or vapor bath.)

At best these observations reveal health researchers and practitioner’s lack of tolerance and understanding of Maya ideas about wellness, illness, and care; at worst, they amount to an expression of outright mockery and ridicule. That the researchers and practitioners would capitalize the portion of Maya interviewees’ accounts concerning their beliefs about wellness (i.e., “Stronger for Agriculture”) has the effect of ironizing them. Also noteworthy here is how the language and tone of science is invoked to produce a terse dismissal of Maya beliefs.
In the medical explanation offered by the health researchers and practitioners on the conditions caused by Maya bathing practices, human subjectivity and lived experience are all but excluded from their description of the illness experience—save the mention of human negligence. Everywhere else, subjectivity and experience are reduced to truth-filled scientific descriptions of the effect of environmental stimuli on living organisms. Observations of this sort are typical in many Guatemalan health practitioners’ cross-cultural commentaries concerning a wide range of Maya health-related practices. These differences of opinion between health care practitioners and the local population concerning biomedical and therapeutic care sometimes lead to serious disputes.

THE SEARCH FOR PATIENTS

Not all of the vaccination efforts of the centro de salud were confined to the clinic, and many of these extraclinical activities were interpreted by Nima’ townspeople as overtly confrontational. Yearly, the centro de salud conducted vaccination campaigns, moving outward from the clinic, which was located at the center of town, and heading into the far reaches of the community that spread throughout the surrounding Nima’ mountainside. The vaccination campaign (in its third year when I was conducting research) culminated in what was called semana nacional de salud. Leading up to this event, centro de salud practitioners and staff began posting flyers throughout the town that read “Vacuna Gratis” (“Free Vaccination”) (an example of one such flyer is illustrated in figure 17). While most townspeople seemed unconcerned or unbothered by these signs, they were well aware of what they indicated.

Though this centro de salud initiative was called semana nacional de salud, it is worth noting that in this context it in fact amounted to a national vaccination week. In visiting the clinic during national health week, I discovered that very little nonvaccination-related health services were available. The clinic was deserted except for the head nurse. The pair of auxiliary nurses who generally conducted the pre- and post-consultations instead canvassed Nima’ going door-to-door offering vaccinations. Correspondingly, this period was the slowest week of the year with respect to clinic attendance, as most “compliant” Maya wellness seekers avoided the centro de salud altogether.
In addition to posting flyers, the clinic also embarked on a public communications campaign in advance of vaccination week that was designed to get the word out about vaccinations to the sizeable
¡Dame una V!   ¡Dame una A!   ¡Dame una C! ¡Dame una U! ¡Dame una N! ¡Dame una A! ¿Qué dice?:

¡Vacuna! ¡Vacuna! ¡Vacuna!

Give me a V! Give me an A! Give me a C! Give me an I! Give me an E! What does that spell?:

¡Vacunaaaant!

I can't hear you. Louder! Vaccine! Vaccine! Vaccine!

No se oye. ¡Mas fuerte! Vaccine! Vaccine! Vaccine!

Dame una V! Dame una A! Dame una C! Dame una U! Dame una N! Dame una E! Oye, qué dice?
nonliterate portion of the Nima’ population. Here, the voice of the centro de salud K’iche’ health promoter was enlisted to promote a biomedical message on the benefits of being vaccinated. In order to accomplish this, a vaccination announcement was drafted by clinic practitioners and then translated into K’iche’ by the health promoter and read into a tape recorder. With a loud speaker hanging out a pickup truck window, centro de salud staff drove around Nima’ repeatedly blasting the vaccination message into its far corners. The score in figure 17 illustrates the first portion of the announcement, a vaccine mantra chanted in Spanish by a group of small children (C) led by a cheerleader (CL).

Townspeople whom I spoke with did not seem in the least bit bothered by these announcements. Some did, however, comment that the announcement was obviously not made by “their own.” They suspected that the children on the recording were not from Nima’. Residents also knew from listening to the announcer’s pronunciation of K’iche’ (in the second portion of the “broadcast not included here) that he was from the town of Nahuala. The belief that the children on the recording were not local combined with the knowledge that the announcer was working for the centro de salud made the vaccination advice and the announcement suspicious in general. Some townspeople whom I spoke with expressed doubts about whether or not the non-Nima’ announcer’s tz’ij could be trusted.

MEDICAL CO-OPTING OF MAYA VOICES

In addition to undertaking these efforts designed to help meet the targets for vaccination coverage that were recommended by the Ministry of Public Health in Guatemala City, the centro de salud also decided to try something completely new; it devised a plan to conduct and videotape a total of twenty interviews with Nima’ residents. The express purpose of these interviews, I was told, was to gain a better understanding of why some Nima’ residents agreed to the vaccinations and why others vehemently opposed them. Thinking that this information would prove a great benefit to my study, I volunteered to be a backup video cameraperson and recorded these field interviews along with centro de salud staff.

Before each interview, the majority of which were conducted in K’iche’, prospective participants were told by the clinic’s staff and independently by me what the recordings would be used for, and their
consent was obtained before any recordings were made. The health practitioners indicated that all recordings would be edited and used to make a promotional video that would be played at the centro de salud while patients awaited their consultations. Working from a list compiled from clinical records of townspeople who had received their full sequence of vaccinations, health practitioners began seeking out potential participants. The first several attempts at participant recruitment ended in failure. In a few of these first attempts, residents would only speak with centro de salud practitioners through the bars of glass lookouts on their front doors.

When practitioners were finally successful in getting some Maya women to participate, I quickly discovered that contrary to what I had initially been told, centro de salud staff was not at all interested in the opinions of those townspeople who neither wanted nor agreed with the vaccine practices. This initiative was only concerned with promoting vaccinations, not with attempting to understand opposition coming from the medically “unreached.”

**DECEPTION AND “EDUCATION” OF THE MEDICALLY “UNREACHED”**

The objective of the interviews was to obtain “testimonies” that could be used as propaganda in the promotion of vaccinations. The idea was simple. If the voices of a sufficient number of “compliant” townspeople could be assembled on a videotape and heard proclaiming the virtues of vaccinations, more of the “unreached Nima’ residents would likely convert and accept vaccinations and embrace biomedicine. Then the Nima’ centro de salud might finally no longer find itself in the unenviable position of being annually recognized by the Ministry of Public Health as one of the municipalities with the least amount of vaccination coverage in all of Guatemala. Not surprisingly then, the interview questions that townspeople were asked tended to be leading and were aimed at producing responses or “testimonies” favoring not only vaccinations but medical treatment at the centro de salud in general.

I was not the only one with misconceptions concerning the clinic’s stated plan for the use of the recorded vaccination interviews (it collected a total of twelve). On the day that the final field interview had been recorded, as we were walking back toward the clinic, I heard one
health practitioner say to another, “Once the tapes are edited, we will take them over to the cable company and have them broadcast throughout Nima’ and the department of Quetzaltenango.” I found this comment odd because before making the recordings, clinic staff had told the participants that the tapes would be played only on a television at the centro de salud in Nima’.

Cautiously, I mentioned what the participants had been told and suggested that if the practitioners intended to use the videos in a different way they would need to go back and discuss these changes with each of the contributors. My concerns were politely dismissed; the practitioners explained that the participants had already agreed to be taped and assured me that they would not care about how the tapes were used. I was bothered by this overt deception on the part of the centro de salud practitioners and troubled by their unwillingness to entertain the idea of consulting participants further. Equally worrisome was the fact that through my participation in the making of these recordings I had, albeit unsuspectingly, become a part of their health campaign.

When we arrived back at the centro de salud the practitioners gathered around the television to view the videotaped vaccination testimonies. When the cameraperson had readied the tapes and the VCR, it was discovered that the camera had improperly recorded the field interviews. With the picture and sound cutting in and out every few seconds owing to an apparent electrical problem within the camera, the recordings were unintelligible. I say “apparent” because for the Maya participants who later learned (through renewed request for interviews) of the intentions of the health practitioners, the fact that the original recordings were unusable came as little surprise. Some went so far as to suggest that when the original participants on the tapes had changed their minds about being recorded, the recordings themselves became corrupted, just like the motives of those eliciting the information.

Although the clinic’s tape wouldn’t cooperate, it was still possible to view the field interviews by having me connect my camera to the television. To my surprise and relief, copies of my tapes were never made because no one at the centro de salud ever purchased the necessary blank VHS tapes as an out-of-pocket expense. Instead, a formal request for funds to purchase the tapes was submitted to the Ministry of Public Health in Guatemala City, and these funds did not arrive during my
time in Nima’. A potentially complicated situation on numerous fronts had been avoided due to bureaucratic paperwork.

Though it is uncertain what the ramifications might have been had the vaccination tapes been broadcast throughout the department of Quetzaltenango, the effects of other vaccination campaign tactics were infamously known for their success and widely recounted by townspeople who experienced them firsthand. As I sought to understand the tensions and conflicts surrounding (re)vaccinations in Nima’ through interacting with townspeople and eliciting their experiences, the retelling of a frightening story of alleged violence and abuse involving centro de salud health practitioners and Maya residents began to emerge.

“SAVE THE CHILDREN”: CIRCUMVENTING NONCOMPLIANT PARENTS

According to accounts by Nima’ residents, in the year prior to my arrival the centro de salud had become increasingly frustrated with the lack of local response to vaccination campaign efforts and with the general noncompliance at the clinic to vaccinations and follow-up visits. A new approach to the problem was formulated. If the Maya of Nima’ were not going to seek “health” on their own then the centro de salud would have to bring it to them. This sentiment led to the vaccination missions into the outlying areas of Nima’ in search of patients among the medically unreached.10

When centro de salud practitioners set out for the outlying areas of rural Nima’, inhabitants would see them coming up mountainside paths and know that they were coming to vaccinate as many men, women and children as possible. From a distance Nima’ residents learned to distinguish between the centro de salud’s vaccination “missions” and their health education outreach initiatives. Residents had come to recognize the little white coolers that health practitioners carried. In Nima’, coolers were associated with two things: ice cream and vaccines. If those carrying coolers wore brown uniforms and did not play the iconic “Turkey and the Straw” tune as they approached, residents knew from experience that the coolers did not contain ice cream for children but vaccines for all.

A K’iche’ midwife from Sololá echoed Nima’ residents’ sentiments regarding these medical encroachments, reportedly telling researchers
that “they [Ladino health practitioners] only come when there is a vaccination campaign and to look for servants for their homes” (Hurtado and Sáenz de Tejada 2001:224). In Nima’, when health practitioners were spotted on a mountain path, residents would tell others nearby of their impending arrival, and many would close their doors before the health practitioners reached the hamlets. Women and children fearing vaccination would go inside while their fathers and husbands would stand threateningly out in front of their homes with the machetes drawn or axes in hand. Other residents who were occasionally caught by surprise reported seeing their entire families vaccinated on a single occasion (see Clastres 1989).

These kinds of reactions to the arrival of health care providers in the outlying areas were echoed by Tomas, the Ladino janitor and driver for the Nima’ centro de salud, who experienced these hostilities from the other side. One evening when the centro de salud had closed for the day, Tomas talked with me about the dangers of his job. He told a story of how he had transported a group of health practitioners into one of the rural hamlets when he suddenly found himself threatened with violence for doing so. In recalling the terrifying moment, he said that on the fateful occasion he had opted to stay back with the truck by the road while the others went ahead into the hamlet. Some Maya men came up from behind and confronted him with machetes in hand, warning that he should either carry his companions away from their homes or risk death. Tomas gladly complied and admits that ever since then he has felt cautious about making trips into the outlying hamlets, adding, “They [the Maya] don’t want us going up there.”

Though many Nima’ residents expressed their aversion to having their hamlets and homes encroached on by the uniformed centro de salud practitioners, one of the most disturbing stories of conflict and alleged abuse did not occur in an outlying area but rather in the center of town. Family and companions of the alleged victims charge that when Nima’ parents had repeatedly refused to have their children vaccinated, centro de salud practitioners converged on the school. Once inside schoolyard gates, practitioners were allowed to enter the classrooms, where unsuspecting children were studying. According to accounts, the teachers left their classrooms and practitioners carrying white coolers entered, locking the doors behind them ensuring that no one could escape. The
families say that then, amid screams of terror and cries for help, health practitioners wielding needles chased and cornered each child, holding and forcibly vaccinating each one. Children returned home later that afternoon and told their families what had transpired. In the days and weeks following the incident, many of the youngsters were reportedly afraid to attend school, and some parents were apparently not inclined to send them back (see Agoritsas, Bovier, and Perneger 2005).

Though I heard this disturbing story recounted on several different occasions, I did not attempt to substantiate it by asking centro de salud practitioners about it directly. I mention the story here not to condemn the centro de salud or its practitioners but rather show that local perceptions (real or imagined) of the depth and severity of biomedical encroachments were strong. This account illustrates not only Maya distrust for certain health care practices but also a kind of resentment and hostility toward those health practitioners who would seek to provide health (or perhaps more specifically vaccines) where it is not sought.

For a significant number of older Nima’ townspeople, Western health care or “vaccinations” and those clinical practitioners who delivered them were perceived as an extension of the Guatemalan government and its past policies, which many still suspected were covertly bent on the extermination of Maya peoples. This sentiment is voiced in local K’iche’ conversations and can also be found in some Maya literature (“Kakaj ri a’re’ kakisach qawach, xa rumal che ri uj” [“They want us disappeared, only because we are Mayas”] [Proyecto Lingüístico Santa María 2000:177]).

Given this sentiment, it is not surprising that many townspeople with whom I interacted saw not only centro de salud vaccination practices but also its methods of contraception as techniques devised by the government to sterilize and/or otherwise “disappear” the Maya population. It followed for them that children who were subjected to vaccinations would be rendered unable to reproduce once they became adults. Similarly, in the case of birth control, at the time of my study, many felt (men and women included) that Maya women were being discouraged from reproducing. It was thought that with these covert tactics (e.g., all manner of nonsolicited planned parenthood and/or birth control paraphernalia), the centro de salud in collaboration with the federal
government had devised a way to have the Maya slowly “disappear” themselves, voluntarily, by their own hand.

**SUPPLANTING THE SACRED (MAYA MIDWIFERY UNDER THE MEDICAL GAZE)**

We now turn our attention to the final area of curative conflict to be discussed in this chapter, the cross-cultural curative disputes that emerged in Nima’ surrounding secular versus sacred care for expectant mothers. Many of the Maya wellness seekers who sought treatment at the centro de salud were expectant mothers (see Jordan 1993). Indeed, for a time two out of every five consultations had a prenatal component. I say “prenatal component” because most Maya wellness seekers came to the centro de salud with their children, family, and companions and in most instances visits were not just intended for the expectant mother but for other members of the wellness-seeker group as well.

Nima’, like other Maya towns and villages throughout Guatemala, had far more iyomab’ than they had any other Maya therapeutic specialist (see Cosminsky 1977, 1982; Walsh 2009). All of the midwives in Nima’ I knew or had heard of were women. Some of them possessed other therapeutic specializations in addition to midwifery. They were also, for example, ajq’ijab’, ajkunab’, and ch’ob’onelab’ (see Colby and Colby 1982; Cook 1986; B. Tedlock 1992b). K’iche’ midwifery combined ritual and obstetrical specialization. Like other Maya therapeutic fields of care (save, perhaps, bonesetters; see Hinojosa 2002), midwives mediate between wellness seekers and supernatural agents through various forms of chak aimed at securing remedial action while simultaneously safeguarding wellness seekers (L. Paul 1974; Paul and Paul 1975).

The majority of births in Nima’ as in other rural Maya areas in Guatemala still occur through the able and helping hands of Maya iyomab’ (see Jordan 1993; Hurtado and Sáenz de Tejada 2001). In fact, statistical studies at the time of this investigation showed that the “Ministry of Health in Guatemala attends only 20 percent of all births” (Hurtado and Sáenz de Tejada 2001:212).¹¹ Not surprisingly, with the medicalization of birth within the past half century or so, the attention of health care (first in Europe and North America and now in the developing world) has increasingly been focused on birth; in aiding it, in managing...
it, in controlling it, and in preventing it (Martin 1992; Epstein 1995; Fraser 1998; Huber and Sandstrom 2001).

Guatemala is no exception. Biomedical inroads into the biosocial domain of birth and the culture of birthing has had the effect of calling into question the sacred/spiritual practices of Maya midwives while promoting the (largely unchecked) objective of bringing the whole of birthing under the jurisdiction of the secular/scientific practices of biomedical models of care (see Schep-Hughes and Lock 1987; Fraser 1998). In practice, this has resulted in a subtle but sustained biomedical effort aimed at diminishing the role of Maya midwives in birthing; their craft has been marginalized as “alternative medicine,” and their work has been replaced with an all-encompassing clinical model of care and control over the birthing process. Biomedical efforts in Guatemala have focused on medicalizing Maya midwifery through official training and licensing (Putney and Smith 1989), a process that secularizes Maya sacred and ritual specializations (Cosminsky 1982; Hurtado and Sáenz de Tejada 2001).

**MIJA AND MIJO (CLINICAL REVERBERATIONS OF INTERETHNIC RELATIONS)**

As I have noted, I undertook detailed ethnographic observations of all aspects of clinical care at the centro de salud long before I made any recordings. During this time I observed numerous prenatal consultations at the primary consultation and during the pre- and postconsultation stages. Because it was during postconsultations that wellness seekers presumably made and/or negotiated health decisions, the medical recommendations that attending nurses made to the expecting Maya mothers provided rich and sometimes disturbing insights into health practitioners’ perceptions of the culture of Maya birthing and parenthood.

One of the first things I noticed when observing nurse practitioner–patient interactions were the sociolinguistic terms that the Ladina nurses used to refer to expecting Maya mothers and other Maya wellness seekers. The use of these terms might be described as a sociolinguistics of dishonorifics (see Brown and Levinson 1987). When medical advice was given out or when demands were made of patients, Ladina nurses would frequently refer to Maya mothers as “mija” or “mi hija,” which literally translates as “my daughter/child.” Sociolinguistically,
with respect to the various social contexts of use, it is interesting to note that Ladin/a/os (Hispanophone) women and men only used the terms “mija” and “mijo” (“my son/child”) when referring to their child and when making demands of a person they socioculturally identified as Maya. Furthermore, I was unable to find a single sociolinguistic context where it was considered socially appropriate for a Ladina/o to say “mija” or “mijo” to another Ladina/o when he or she did not recognize the socio-familial relationship that such terms denoted (see Stutzman 1981). However, it was sociolinguistically appropriate and frequently the case that Ladin/a/os of any age would and did call persons who they understood to be Maya “mija” or “mijo,” regardless of the absence of socio-familial relations and in spite of any differences in age.

When I asked a Maya wellness seeker what she thought of this reference, she pointed out that this could be heard not only at the clinic but also in the market where the Nima’ townspeople went to sell their goods. Ladino (Hispanophone) customers frequently called them “mija” or “mijo.” While many Nima’ young people I spoke with said that they had not noticed this usage, they added that they would never refer to each other or to strangers in this way, observing that such references showed a lack of respect. On the other hand, some older residents pointed out that they recalled that when they were young (in most cases, fifty plus years ago), the Ladin/a/os did not call them “mija” or “mijo” but instead María and José. They went on to explain that the Ladino folk belief was that if one called a Maya male José (biblical reference to Joseph) or a female María (biblical reference to Mary) one would likely have guessed the correct name and the Maya referent would respond to whatever the non-Maya speaker’s request might have been. These names were thought by outsiders to be popular among Maya peoples. Maya elders added that this assumption was obviously incorrect and that the appropriate (cross-cultural) way of referring to them would have simply been the same way that Ladin/a/os referred to one another when interacting with unknown persons; that is, by saying, for example, “don,” “doña,” “señor,” “señora,” “señorita,” and “joven” (a word meaning “young person”). More culturally appropriate still, Maya elders would not have been referred to as children but as “tat” (“father”) or “nan” (“mother”).

In a nearby village, I observed the remnants of older practice of calling Maya peoples José and María. My research assistant and I
accompanied a young Ladina woman who was looking for prospective Maya students to participate in a literacy project. When we were within earshot of each house, the Ladina woman would call out “María!” My first thought was that she must have known the women at each house, but I soon found it curious that at each house there would be someone named María. Eventually, Xuan, my research assistant asked the Ladina woman, “Is every woman here called María?” I mention this experience and make this observation on cross-cultural differences in what are appropriate ways to referring to strangers because these differences speak to larger issues (past and present) of Ladino/Maya social asymmetries and inequalities that reverberate in curative encounters.

**MEDICALIZING BIRTH AND MARGINALIZING MIDWIVES**

With this sociocultural dynamic of Ladino-Maya interactions in mind, we now return to the discussion of clinical interactions between nurse practitioners and expectant mothers at the centro de salud. Over time, I began to notice certain patterns emerging in the kind of prenatal advice
that was offered to Maya wellness seekers. I now briefly discuss some characteristics of several prenatal postconsultations that illustrate the kinds of patterns found in prenatal medical advice at the centro de salud and examine how they relate to cross-cultural disputes and tensions.

The first example is that of a postconsultation between a nurse and a Maya woman who was forty-nine years old and two months away from giving birth to her fifth child. When the attending nurse had finished explaining to the expectant mother the dosage regimen for the prescribed vitamins and supplements, the nurse urged her not to seek the assistance of a Maya midwife. The nurse told the expectant mother that because she was now a little older, it would be very important that she have her birth attended to by trained health professionals at one of the public or private hospitals in the nearby city of Quetzaltenango. She added that in the hospital health professionals had access to all of the medicines and equipment needed to attend any complications that might arise during childbirth. Considered in isolation, this medical advice did not stand out as unusual until I began accumulating numerous other examples of prenatal advice.

On another occasion, a Maya mother and father of fifteen and seventeen years of age (respectively) were expecting their first child. In the prenatal postconsultation the nurse explained to them that the physician had found that their child was indeed in the proper position for the particular trimester the mother was in and that the pregnancy appeared to be going very well. The mother, father, and their companion were visibly pleased with this news and had gathered their belongings and were beginning to leave the consultation area when nurse called out, “Mija, oyes!” (“My daughter/child, listen!”). “Don’t go and see a midwife, you need to go to the hospital in Quetzaltenango to have your baby.” The family, who had been heading out of the door, reentered the consultation room and stood by the nurse’s desk. They listened attentively as she explained why, under no circumstance should they have a midwife attend the birth. The nurse said, “¿Este es su primer hijo, y porque eres inexperto su hijo sería más seguro si se entrega en el hospital. Allí, ellos pueden cuidar de emergencias no planificado. Desea un bebé saludable, verdad?” (“This is your first child, and because you are inexperienced your child would be safer if delivered in the hospital. They can take care of unexpected emergencies there. You want a healthy baby, right?”). “Sí,
por su puesto” (“Yes,” of course”) and “Sí” (“Yes”), the expectant parents and companion responded.

In observing numerous prenatal postconsultations like these, I discovered that the nurses could nearly always find some aspect of each pregnancy (the mother’s age, her weight, the order of the birth, etc.) that warranted discouraging the expectant parents from having births attended to by Maya midwives (see Foucault 1972, 1973; Di Matteo and Di Nicola 1982). For centro de salud nurses, the work of Maya midwifery was steeped in mystery, uncleanness, and suspicion. Their practices where seen as outmoded and, in some cases, reckless. In the estimation of some health practitioners in the highland area, Maya midwives were “responsible for high morbidity and mortality among pregnant women and newborns” (Hurtado and Sáenz de Tejada 2001:227).

Centro de salud nurses freely gave out what was for them the “acultural” medical advice to stay away from midwives. Their suggestions came out of a genuine belief that such recommendations were helping to disabuse Maya peoples of harmful ideas about birth and the birthing process. Until practitioners could successfully convince wellness seekers to avoid the services of midwives altogether, their goal (as other investigations have suggested) was to have midwives “change their ways” (Hurtado and Sáenz de Tejada 2001:227). If Maya midwives were not going to go away, they could fill the role of temporary helpmates in the delivery of biomedical health care. Select midwives could only become health care collaborators or “partners in healing” after they had undergone government-mandated training and official licensing, a process that actively sought to replace “illogical” Maya sacred and religious birth rituals with “scientifically sound” and secular biomedical practices. This government-training mandate stated, among other things, that “any midwife who fails to attend a training course after being summoned is prohibited from attending deliveries” (Hurtado and de Tejada 2001:216).

Bringing Maya midwives into the biomedical fold also provided health practitioners with yet another way to co-opt Maya voices as authentic advocates of biomedical legitimacy and authority. One of the most salient examples of this kind of co-opting was an instruction delivered during official training to the effect that Maya healers ought to recommend that the wellness seekers in their care not give birth in their homes but instead in hospitals. In an ethnographic investigation
conducted in the Guatemalan departments of Sololá, Totonicapán, Quetzaltenango, and San Marcos, Maya midwives reported that

if they [the midwives] recommend to pregnant women that they should go to health services, about half of them do not comply. . . . Women are afraid of vaccines because they think they can cause an abortion or make the woman swell, and they are ashamed because they cannot speak Spanish and because of exams performed. Some women are also afraid because of rumors about sexual abuse during gynecological exams and because of beliefs that the “pills” provided can produce an abortion, function as a contraceptive, or sterilize them. (Hurtado and Sáenz de Tejada 2001:224–25)

These cultural commentaries made to Guatemalan researchers illustrate many Maya sociocultural perceptions about biomedical practitioners and practices that were at the heart of disputes discussed in this chapter.

Maya midwives who are trained and licensed by the Guatemalan Ministry of Public Health and the World Health Organization (WHO) are instructed to refer expectant mothers in their charge to “official” health services, a practice at odds with basic Maya notions about the healer’s “calling” and duty to their don and their uwach uq’ij. For midwives this call to heal is “a sense of responsibility, commitment, ‘law,’ or ‘mandate’” that compels them to provide care “from the moment that a pregnant woman or her relatives go talk to them to ask them the ‘favor’ to see a pregnant woman to the time when she is ‘normal’ again” (Hurtado and Sáenz de Tejada 2001:220). But why would making medical referrals for health services necessarily conflict with a midwife’s code of cultural responsibility to their wellness seekers? Could not the midwives simply accompany expectant mothers in their interactions with health service agents and agencies? Researchers working in highland Guatemala report that Maya midwives are frequently not allowed to accompany wellness seekers at hospitals. When they do accompany wellness seekers, hospital receptionists demand that they present their “papers” (i.e., official license) (see Huber and Sandstrom 2001). Midwives have also reported unfriendly treatment at hospitals; for example, they claim that their relatives, who accompany them, are often “scolded” (Hurtado and Sáenz de Tejada 2001:226).
But while official training that urges midwives to make medical referrals can put them in difficult positions as cultural intermediaries, the instruction that they actively promote birth control and/or planned parenting to the wellness seeker in their charge (Leedam 1985) is perhaps the most controversial and problematic of all. As the commentaries of K’iche’ and Mam-speaking midwives from the various Guatemalan departments demonstrate, Maya healers were well aware of the fear that those in their charge had of vaccines and the common associations of vaccinations and “pills” with involuntary abortions, contraception, and sterilization. Though the Guatemalan Ministry of Public Health and WHO strongly encourage midwives to promote birth control (see Cardelle 2003), my research did not document a single case in which a Maya midwife (see B. Tedlock 2005) ever promoted or utilized any medical practice that could have been remotely associated with those tactics presumed to be linked to “disappearing” the Maya.

**PLANNED PARENTOOD, THE DISAPPEARING MAYA, AND PATHOLOGIZING CULTURE**

Planned Parenthood and vaccines advertised at a centro de salud, near the town of Nima’. Photograph by author.
Returning now to my discussion of the tensions emerging from the kinds of medical advice that nurse practitioners gave expectant Maya mothers, I note that Maya preferences for having midwives attend births was not the only cultural practice called into question by the medical advice offered at the centro de salud. Expectant mothers were also told that their traditional Maya dress was a hindrance to the healthy growth of a child in the womb.

Not only in Nima’ but throughout Guatemala the majority of Maya women continue to wear a variation of the customary po’t, uq’, and xaq’ap (see Hendrickson 1995). At the centro de salud during pre- and postconsultations, it was not uncommon to hear nurses suggest to Maya wellness seekers that their indigenous skirts were too heavy and that their belts were worn too tightly around the waist. These comments were followed by health-based accounts explaining that these clothes did not allow their babies to grow properly. In fact, on one occasion a nurse went so far as to tell an expectant mother that it was the clothing that was primarily responsible for low birth weight in Maya children. The implication was that this problem could easily be prevented if Maya women would just wear “normal”/Western clothes.

How does this kind of medical advice affect the “birth care” decisions that expectant mothers make? Ethnographic investigations into this question suggest that Maya wellness seekers (not only with respect to prenatal care but in care for the sick in general) continue to negotiate and move through pluralistic fields of care. Despite biomedical efforts like those described here, expectant mothers who sought biomedical care did not abandon Maya therapeutic care but rather were frequently attended to concurrently by biomedical practitioners and Maya midwives (Cosminsky 1977, 1982; Acevedo and Huratado 1997; Hurtado and Sáenz de Tejada 2001; Adams and Hawkins 2007).

By exploring one source of deep contestation from various sides of the conflict, this chapter has brought to light a number of issues that lie at the heart of many cross-cultural curative disputes in the Nima’ area between Maya wellness seekers and biomedical practitioners. I have examined the biomedical creation of compliant patients, a process that extends from the microinteractional strategies used by practitioners to secure clinical compliance to the vaccination campaigns that reach ever
deeper into uncharted cultural areas in the search of patients among the medically “unreached” to the “legitimate” violence of targeted vaccination efforts aimed at “saving” the children from the monsters of medicine (childhood disease and death) to the secularization of all aspects of birth, birthing, and care for the sick through the authority of science to the long-term struggle for a kind of medical supremacy based in naturalizing and extending the role of biomedical patient. Linking the disputes observable in the various domains of contestations discussed here is the medical struggle for curative dominance in Nima’ in which Western practitioners disseminate a monologic model of care by strategically co-opting or enlisting multiple voices of Maya and representing them as the authenticating voices and advocates for biomedicine.
EPILOGUE

Vital Voices

When it is genuine, when it is born of the need to speak, no one can stop the human voice. When denied a mouth, it speaks with the hand or the eyes, or the pores, or anything at all. Because every single one of us has something to say to others, something that deserves to be celebrated or forgiven by others.

A CUE FROM K’ICHE’ STORYTELLING

In this study of language use in health care, by treating communicative interactions in biomedical and therapeutic encounters in Guatemala as an unfolding scene of lived experiences that can only be “followed” by the ethnographer and never quite “fixed,” I have sought to offer a scientific approach to the study of living interactions that is not irritated by their indeterminate quality or frustrated by uncertainties. A conclusion to some degree is but another attempt at “fixing” meanings in which one voice dominates over the interplay of multiple voices, and as such it is something that this investigation has tried to avoid. My remarks, then, are only concluding and not a conclusion. Dennis Tedlock, writing of trace and voice among the K’iche’ tells us that

a Quiché story does not begin with a series of formal opening announcements that call a halt to conversation and point only into the story, and it does not end with a series of formal closures that call a halt. . . .

. . . A Quiché story does not carry us away into another world or another eon, a separate reality that has no connection to the world of the conversants. It does not go on for an hour, or even half an hour, but lasts only five or ten minutes,
and once in a great while twenty. The story does not move strictly forward along the path of its event, but always gets a little ahead of itself here and looks back on itself there.


Following the lead of K’iche’ storytellers, this work has tried not to carry its readers into another world with no connection to their own, it has gone on but for a moment, and now it decomposes with no formal closure as chapter 1 was co-composed with no formal opening, always getting a little ahead of itself here and looking back on itself there.

This study has approached K’iche’ Maya intracultural therapeutic and cross-cultural biomedical interactions in Nima’, Guatemala, with the aim of understanding the sociolinguistic variations in doctor-patient and healer-wellness seeker interactions that produce complications in cross-cultural medical interactions. To do this a polyphonic or multivoiced approach has been developed and utilized to examine curative interactions. Using a “polyphonic score” as a method of description, my aim has been to highlight what was sociolinguistically distinct in both K’iche’ and Ladino (nonindigenous) ways of understanding wellness, illness, and care and of speaking about them.

To the degree that it has been possible, an effort has been made to not allow the method of description (the polyphonic score) do what conventional methods of linguistic description (transcripts) have tended to do; that is, inadvertently make the described (living communication) obedient to the structure of the description. Instead, the aim of the polyphonic score is to conform to the movements and indeterminacies of living interactions.

**POLYPHONIC APPROACH REVISITED**

The polyphonic or multivoiced approach to the study of language use in health care is also concerned with the voices that phonocentric linguistic descriptions (transcripts) would conceal if applied to the study of Maya cross-cultural biomedical and intracultural therapeutic interactions. With a polyphonic score, the multiple voices of all ratified participants in an interaction can be given equal representation throughout a communicative scene, regardless of whether or not they are speaking or making silence at any given moment. Scoring a communicative scene
polyphonically means representing silent interactants who are conventionally absent from standard transcripts and providing them with a space, a voice, on the written page alongside speaking interactants. Including silent interactants in our representations of the communicative scenes places their communicative contributions, with all of their uncertainties and mysteries, on a more equal footing with those of speaking interactants. In being able to see (with the polyphonic score) the representations of making silence take shape in the communicative scene we can identify these silences as communicative acts that have describable discourse roles associated with them. This discovery makes it possible to describe and analyze speaking and communicative silences as equally meaningful communicative acts.

**INTERACTIONAL PRACTICES AND DISRUPTIONS IN BIOMEDICAL AND THERAPEUTIC CARE**

Studying K’iche’ and Ladino language use in biomedical care from a polyphonic approach reveals a number of the communicative and comportment practices, foreign and common, associated with the sociolinguistic roles of Ladino doctors, Maya wellness seekers, and Maya companions that inform their behavior in and their expectations about curative encounters. At the Nima’ centro de salud, though the medical interview was the form the physician’s communicative interactions with would-be patients took most often, the corresponding communicative practices of Maya wellness seekers and their companions did not always interactionally reciprocate the practices typically associated with the sociolinguistic role of the patient. “Doctor-patient” interactions are defined as such because they presuppose an interaction between two individuals, a single doctor and a single patient. Maya wellness seekers and their companion(s) most frequently entered the biomedical encounters together, a comportment practice that disrupted some of the fundamental sociolinguistic presuppositions of the doctor-patient relationship.

But the sociolinguistic disruptions that Maya wellness seekers and their companion(s) caused to the doctor-patient relationship went beyond introducing multiple actors in curative encounters. The social role of the patient in a biomedical interview is conventionally that of the principal respondent to a health practitioner’s inquiries. The clinical
practice of treating the individual patient as the primary respondent has the effect of locating the illness under examination squarely within the experience of a single patient, who it is presumed can speak best about the illness that he or she is thought to “own.” The sociolinguistic roles that Maya wellness seeker and their companion(s) bring to curative encounters (both biomedical and therapeutic) produce illness narratives that are dialogues, interactionally co-composed of the multiple voices and pluralistic experiences of all of the participants, rather than monologues in the voice of a single patient.

In Nima’, this Maya interactional strategy had an effect on the medical interview; the physician in cross-cultural consultations did not insist on directing his questions to an individual patient but rather directed them to both Maya wellness seekers and their companions. But the limits of the physician’s communicative adaptability to Maya interactional styles was demonstrated when he physically examined wellness seekers, requesting with the immediacy of physicality that a single individual respond to the medical inquiry. For example, touching the wellness seeker the physician would say, “Does it hurt here?” This communicative and comportment practice (a question plus physical contact) disrupted the co-composed interactional styles of Maya wellness seekers and their companions and produced a response that came in a single voice, the voice of the patient.

Maya wellness seekers and their companions, therefore, did not merely influence the sociolinguistics of biomedical encounters; their communicative practices were also influenced by the interactional strategies of health practitioners and medical encounters. During a biomedical encounter, Maya wellness seekers and their companions are interactionally moved into and out of the sociolinguistic role of patient. That is to say, though they frequently responded to the physician’s questions with multiple voices and pluralistic experiences (a practice uncharacteristic of the role of patient but common to the role of Maya wellness seeker and their companions), they nevertheless assumed the sociolinguistic role of patient as respondent by providing the majority of the responses in the consultation. Furthermore, as patients in biomedical consultations, Maya peoples neither asked many questions of the physician nor initiated much of the communicative action. Instead, in biomedical consultations Maya patients most often spoke only when
they were prompted by the physician to do so. By comparison these communicative practices were uncharacteristic of the sociolinguistic roles of the Maya wellness seekers and their companions in intracultural therapeutic interactions during which they frequently initiated communicative acts and asked questions.

This picture of Maya ways of speaking about wellness, illness, and care comes into even sharper focus when the polyphonic approach is applied to Maya intracultural therapeutic interactions. Because many of the techniques used to study language use in health care were designed principally for examining doctor-patient interactions, the theories and methodologies informing them assume a certain set of sociolinguistic relationships and interactional practices common to biomedical encounters. In relation to Maya intracultural therapeutic interactions, the most problematic assumption of these methodologies (beyond the premise that the interaction takes place between a single doctor and a single patient) is the idea that the medical interview is the speech event at the center of curative interactions and that most other communicative acts (e.g., turn takings, topic control, interruptions, etc.) revolve around it.

**SOCIOLINGUISTIC STRATEGIES AND EXPECTATIONS IN HEALTH CARE INTERACTIONS**

Applying the polyphonic approach to an intracultural therapeutic interaction recorded at the dispensario in Nima’ demonstrated that far from being the center of the interaction, the medical interview was altogether absent from K’iche’ curative consultations. The medical interview was, in point of fact, a nonspeech event in K’iche’ repertoires. But this discovery about the interactional practices of Maya intracultural therapeutic consultations provided more questions than answers. Maya healers asked significantly fewer questions than did their Ladino health practitioner counterparts, and Maya wellness seekers and their companions initiated more of the communicative action and asked significantly more questions in therapeutic consultations than did Maya patients in biomedical consultations. If K’iche’ healers did not rely primarily on question-and-answer sequences to obtain wellness and illness information from Maya wellness seekers, then how were they so effective in eliciting such information?
The polyphonic score of the intracultural therapeutic consultation shows that the sociolinguistic role of Maya healers is primarily that of “respondent” in the communicative scene of Maya storytelling and specifically in the retelling of the illness narratives. In therapeutic interactions then, the sociolinguistic roles of Maya wellness seekers and their companion(s) are that of narrator and conarrator. They co-compose illness narratives in an unfolding dialogue featuring the complex interplay of turn taking, interruptions, repairs, reciprocal transitions, questions, and interjections. Maya healers elicit illness narratives by providing a communicative space within the therapeutic scene for the illness narrative to emerge in interaction. To do this, Maya healers coax illness narratives into being with the interactional strategy of answering whereby the Maya narrators and conarrators (wellness seekers and companions) are encouraged to retell their illness narrative.

If it can be said that the primary speech event in biomedical consultations is the medical interview, then in Maya therapeutic consultations it is the illness narrative. Both elicit information and both are interactionally produced. From the retelling and social sharing of the Maya illness narrative emerges a dialogue of multiple voices and pluralistic experiences that co-composes the retrospective diagnosis of the illness that it is hoped will be cured through divine agency. Similarly, it is the physician’s directed questions and the patient’s responses to them that monologically compose (for the physician) a symptomology. Out of this emerges a unilateral diagnosis, a monologue produced for the patient that is spoken not in the subjective voice of the physician but rather in the objective, authorless voice of biomedicine.

The sociolinguistic expectations of Maya wellness seekers and their companions is that Maya healers will facilitate a dialogue; asking too many questions or talking too much can interactionally cause the narrator and conarrator(s) to doubt the ability of the healer and in some cases withhold wellness and illness information. The real potential for serious medical misunderstandings arises when Maya wellness seekers and their companions carry these sociolinguistic expectations of Maya healers over into their interactions with Ladino (nonindigenous) physicians, who rely heavily on the medical interview structure (that is, who ask questions and talk a lot).
The polyphonic approach that implicates the discourse roles of communicative silences in the analysis of language use in health care shows that some complications in clinical communication can result from the interactional exclusion of the meaningful making of communicative silences. In cross-cultural biomedical encounters, we have discovered that speaking-centered explanations of some complications in clinical communication are not always sufficient. For example, conventional studies of language use in health care have sought to explain why multiple questions asked of patients in rapid succession consistently go only partially answered by counting the numbers of questions asked. Such an approach overlooks the discourse roles of communicative silences. Our polyphonic analysis of the interactions of participants’ speaking and communicative silences in medical encounters shows that questions not followed by the necessary communicative silence that fulfills the discourse role of “eliciting” were not given a response. This suggests that even a single question not followed by the required communicative silence that elicits would be missing a relational component to its meaning that could cause it to go unanswered, a point overlooked by speaking-centered approaches to miscommunication.

Similarly, as I have mentioned with regard to the curative scene of Maya therapeutic healing, if the healers ask too many questions or talk too much it can lead wellness seekers and their companions to withhold information. It is, therefore, not only the Maya healer’s ability to answer the narrator and conarrators illness narrative that successfully draws forth wellness and illness information. It is also the Maya healer’s competence in making the appropriate communicative silences that function to sustain, uphold, repair, elicit, and open that makes way for a multivoiced dialogue and deters a homophonic monologue. Tables 1 and 2 compare and contrast some of the most salient characteristics of Maya intracultural therapeutic and cross-cultural biomedical interactions discussed in this work.

**COERCION, VIOLENCE, AND CONTESTED BIOMEDICAL TREATMENTS**

This study has also examined how conflict and human suffering can emerge when coercive communicative practices of health practitioners
Table 1
CROSS-CULTURAL COMPARISON BETWEEN MAYA THERAPEUTIC AND BIOMEDICAL HEALTH PRACTICES

<table>
<thead>
<tr>
<th>Maya Therapeutic Practices</th>
<th>Biomedical Practitioner Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scene of Curative Encounters</strong></td>
<td><strong>Scene of Curative Encounters</strong></td>
</tr>
<tr>
<td>At the Maya clinic, via house calls, at mountainside altars and sacred ruins</td>
<td>At the clinic, in hospitals, and in consultation rooms</td>
</tr>
<tr>
<td>Duration: range from 10 to 50 minutes</td>
<td>Duration: range from 2 1/2 minutes to 4 minutes</td>
</tr>
<tr>
<td>Discretionary compliance with wellness advice</td>
<td>Mandatory compliance with health advice/reprimand</td>
</tr>
<tr>
<td><strong>Social Composition of Care</strong></td>
<td><strong>Social Composition of Care</strong></td>
</tr>
<tr>
<td>Single or multiple Maya healers</td>
<td>Single physician or single nurse</td>
</tr>
<tr>
<td>Wellness seeker(s), family, companions</td>
<td>Single patient, optional family, and companions</td>
</tr>
<tr>
<td><strong>Sociolinguistic Roles of Interactants</strong></td>
<td><strong>Sociolinguistic Roles of Interactants</strong></td>
</tr>
<tr>
<td>Who asks questions? Any ratified interactant</td>
<td>Who asks questions? Primarily physician or nurse</td>
</tr>
<tr>
<td>Who answers questions? Any ratified interactant</td>
<td>Who answers questions? Preferably the patient</td>
</tr>
<tr>
<td>Who tells illness narratives? Wellness seeker, family, and companions (co-composed)</td>
<td>Who tells illness narratives? Preferably the patient</td>
</tr>
<tr>
<td>Who offers the diagnosis? Negotiated between physician or nurse</td>
<td>Who offers the diagnosis? Declared by wellness seeker, family, companions, and healer(s)</td>
</tr>
<tr>
<td><strong>Communicative Practices</strong></td>
<td><strong>Communicative Practices</strong></td>
</tr>
<tr>
<td>Language of care: Maya</td>
<td>Language of care: mostly Spanish</td>
</tr>
<tr>
<td>Primary speaker(s) in curative interactions: wellness seekers, companions, and family</td>
<td>Primary speaker(s) in curative interaction: physician or nurse</td>
</tr>
<tr>
<td>Secondary speaker(s) in curative interactions: healer(s)</td>
<td>Secondary speaker(s) in curative interactions: patients, optional companion, family</td>
</tr>
<tr>
<td>Participatory structure: polyphonic dialogues</td>
<td>Participatory structure: homophonic</td>
</tr>
<tr>
<td>monologues</td>
<td></td>
</tr>
<tr>
<td>Eliciting information: “answering” the narratives of wellness seekers, family, and companions</td>
<td>Eliciting information: medical interview/ “questions and answers”</td>
</tr>
<tr>
<td>Infrequent questions from healers</td>
<td>Frequent questions from physician or nurse</td>
</tr>
<tr>
<td>Kinds of questions: primarily open-ended</td>
<td>Kinds of questions: primarily closed-ended “yes/no” and tag questions</td>
</tr>
</tbody>
</table>
are coupled with remedial actions (however efficacious) that are contested and disputed by patients and wellness seekers. To highlight these conflicts I have used a polyphonic score to describe and analyze an archetypical (Ladina) nurse practitioner-(Maya) patient interaction and show how microinteractional practices and strategies are used to produce clinical compliance with vaccination mandates. The practitioner-patient consultation shows that without an *achi’l* in clinical interactions, would-be Maya wellness seekers are unable to offer the multivoiced responses that are characteristic of Maya interactional strategies. As Maya (individual) patients they are unable to disrupt (by communicative or comportment means) the interactional strategies of medical interviews with its question-and-answer sequences.

*Centro de salud* postconsultations were supposed to be opportunities for Maya patients to ask questions and make choices about treatment. However, by using closed-ended yes/no and tag questions, nurse practitioners frequently failed to provide Maya patients with a choice of health treatment options and instead rather consistently coerced Maya patients into submitting to the prescribed treatments that they opposed

<table>
<thead>
<tr>
<th>Table 2</th>
<th>QUANTITATIVE COMPARISON OF THE DISTRIBUTION OF COMMUNICATIVE PRACTICES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intracultural Therapeutic Interactions</strong></td>
<td><strong>Cross-Cultural Biomedical Interactions</strong></td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td><strong>Duration</strong></td>
</tr>
<tr>
<td>13 minutes 31 seconds</td>
<td>1 minute 55 seconds</td>
</tr>
<tr>
<td><strong>Number of Questions Asked</strong></td>
<td><strong>Number of Questions Asked</strong></td>
</tr>
<tr>
<td>Healer: 14</td>
<td>Doctor: 23</td>
</tr>
<tr>
<td>Wellness seeker: 8</td>
<td>Patient: 0</td>
</tr>
<tr>
<td>Companion: 5</td>
<td>Companion1: 1</td>
</tr>
<tr>
<td>Companion 2: 5</td>
<td></td>
</tr>
<tr>
<td>Baby: 0</td>
<td></td>
</tr>
<tr>
<td><strong>Interactional Affirmations:</strong></td>
<td><strong>Interactional Affirmations:</strong></td>
</tr>
<tr>
<td>Healer: 70</td>
<td>Doctor: 2</td>
</tr>
</tbody>
</table>
and tried to avoid (see Frankel and Beckman 1989a). The medical treatment most disputed and contested by Maya peoples are the vaccination policies and practices of the centro de salud. For health practitioners, vaccinations are the most necessary treatment and the most misunderstood.

The coercive communicative practices used to achieve medical objectives were not limited to the microinteractional practices that relied on the unequal communicative competencies of health practitioners and Maya patients. The stated goal of health practitioners was to promote and deliver health care and if the Maya populace (for whatever reason) was not going to seek health, then practitioners were obligated (they thought) as “providers” to bring it to them by virtually any means necessary (see Roberts 2002).

In the name of health care, vaccination propaganda that unashamedly co-opted “authentic” Maya voices (in Maya languages) was broadcast by radio and used during a national health week dedicated primarily to vaccinating those medically unreached portions of the Maya population. Biomedical propaganda was further carried by practitioners into the outlying areas of rural towns and villages. Noncompliant school-age children were allegedly targeted in massive vaccination efforts that circumvented the permission of “uneducated” parents for the sake of the children, and the strongholds of scared Maya healing came under biomedical attack as expectant Maya mothers were discouraged from seeking the care of Maya healers and told that their conventional dress was an obstacle to their good health. All of this was done in good faith and with a genuine belief in the virtues of biomedicine by practitioners who were dedicated to promoting and providing health to the Maya.

This study has not been an attempt to give “voice” to Maya peoples. Like every people, they have voices of their own. Rather I have attempted only to share some of the voices and experiences from Guatemala that shaped and changed both my research and life. Somewhere the various conversations and interactions that informed this work are unfolding even now, in distant places. It is hoped that any conversations that this work might bring about will contribute to that ceaseless unfolding.
Appendix A

Polyphonic Score

Bar 1.
WS: Chich’a k’u chi re wach ri k’ax.
B: ¿Muy bien Isabel, cuéntame en qué te puedo servir? ¿Qué te está pasando?
C1: Mire, ¿Jas wach ak’ax?
C2: ¿Eh, en la vez pasada qué?

Bar 2.
WS: Arese, re kinb’ij xinpe k’u wa che ri jun viaje ri in. Je, kub’an ch’u kut
B: doctor, no puedo decir. Ji, ji.
C1: Aresé re kinb’il xripe K’u wa che ri jun viaje ri in. Je, Kuhpan che K’u.
C2: ¿Dice que vino a... regló aquel la vez pasada dijo ella—es que la enfermedad que tiene,

Bar 3.
WS: le junmúl la vile de chik.
B: ¿dice que se vino otra vez. A veces se hinca su estómago en la noche, en el día.
C1: Dice que vino a... Tédlo anque la vez pasada dijo ella—es que la enfermedad que tiene,
C2: dice que se vino otra vez. A veces se hinca su estómago en la noche, en el día.
Bar 9.

WS:

B:

C1:

Ya tiene un mes.

Sí.                          ¿que ya no toma pastillas.

C2:

D:

¿Un mes . . . que ya no toma pastillas?

Bar 10.

WS:

B:

C1:


C2:

D:

¿Mientras tomó las pastillas estuvo bien?

Ahora, ehh . . .          otra vez?                volvió el problema.

Bar 11.

WS:

B:

C1:

Sí. Otra vez.

C2:

D:

Muy bien. Haga me el favor de acostarse Isabel, allí en la camilla, donde es, donde duele?

Bar 12.

WS:

B:

C1:


C2:

D:

Bar 5.
WS: Huh . . . jas . . . jas wach xuyo'o?
B: Le dijeron tratamiento, qué, qué pastillas o qué fue lo que le dimos aquí? ¿Qué fue lo que le dije que tenía?
C1: Sí. Es úlcera o . . .
D: ¿El tratamiento que le dimos son las cápsulas blancas? Que tomará veinte-
Bar 6.
WS: Sí. Sí hubo.
B: Sí.
C1: Sí. En tonces . . .
D: ocho días? ¿Sí? ¿Hubo alivio con estas cápsulas? ¿Y cuánto tiempo tiene ya
Bar 7.
B: Sí.
C1: La k'o jun, joropa k'o jun ik'.
C2: Le dijeron que le dijimos que lo que le dijimos antes? ¿Qué fue lo que le dije que tenía?
D: El tratamiento que le pasamos o gave fue lo que le dijimos antes? ¿Qué fue lo que le dije que tenía?
Bar 17.

WS: Sí.

B: Sí, ah.

C1: que meter una sonda por la boca para llegar a ver que hay en el estómago. En tonces, este es un examen.

C2:

Bar 18.

WS: In

B: kinwa wa a le.

C1: Sí.

C2:

D: especial que solo lo hacen en el hospital o lo hacen doctores en lo privado. Los especialistas. Pienso que es lo que hay.

Bar 19.

WS: kinwa wa a le.

B: Sí.

D: que hacer con Isabel. Porque si no le vamos a estar dando medicina ... va estar bien. Cuando haya tomado la.

Bar 20.

WS: kinwa wa a le.

B: Sí.

D: medicina otra vez mal... En tonces no eso no es bueno. En tonces, yo le voy a recomendar.

C1:

C2:

SL:

SL:

SL:

SL:

SL:

SL:
Bar 13.

WS: Aquí.

Sí: WS

B: 

C1: Está inflamado. Sí.

C2: 

D: Está inflamado, está. ¿Bueno, la, la vez pasada se hizo un examen de rayos X, verdad?

Bar 14.

WS: [inaudible]

B: 

C1: No, no fue. No.

C2: 

D: Sí, una serie gastromona [inaudible]. ¿Un examen de varas radiográficas? ¿No, ella no... ¿No se hizo?

Bar 15.

WS: Mhmh.

B: 

C1: No. No. No, no.

C2: 

D: ¿No se hizo... ningún examen? Ah, bien. El asunto es que muy probable que ella tenga algo malo allí en su estómago. Y eso, hay que hacer un examen especial de la misma estomagaulcina.

Bar 16.

WS: 

B: 

C1: Ahh... 

C2: 

D: Pueden hacer un examen especial que se llama endoscopia. Tienen
Bar 25.

WS: ¿Sólo lo voy hacer para consulta externa del hospital, síntese un momento.

D: ¿Por qué si no le vamos a dar otra medicina y . . .

E: está servida

Vaya pues

D: ¿Sólo que no le vamos a dar otra medicina y . . .

Vaya pues.

Ah, hm . . . va.

No sabía . . .

Vaya pues.

Bar 26.

WS: Oh, hm . . . va.
Bar 21.
WS: Ahh . . .
B: 
C1: 
C2: ¿Pero es el mismo que aquí, que le van a dar 
D: que vaya al hospital para que urge ya si pueden hacer los exámenes

Bar 22.
WS: 
B: 
C1: Va hacer una nota vaya 
C2: o no? Ahh. 
D: Yo le voy hacer una nota . . . papelito para que vaya consulta externa del hospital. Tiene que pasar con 

Bar 23.
WS: 
B: 
C1: Sólo estómago. Ahh. 
C2: o no? Sólo estomago doctor que su especialidad es solo estómago. Pero este serán los especialistas gastroenterólogos. Porque solo su 
D: 

Bar 24.
WS: 
B: 
C1: Sólo esto 
Bar 5.

WS: Was there one how many one month?

B: 

C1: Uh, what . . . what . . . was the essence of what he gave you?

C2: The y told her

D: treatment, what, what pills or what was it that we gave you here? What was it that I said you had?

Bar 6.

WS: It's an ulcer or . . .

B: 

C1: Yes.                                                                                                                                 So then . . .

C2: Yes .         Yes .                                                                         Yes .

D: The treatment that we gave you were the white capsules? Yes? Was there alleviation with those capsules?

Bar 7.

WS: Yes. Yes, there was. . .

B: 

C1: . .

C2: . .

D: The treatment that we gave you were the white capsules? That she took for twenty-eight days? Now, she's not taking the capsules for how long?

Bar 8.

WS: 

B: 

C1: 

C2: Has there been now
Bar 1.

WS: You all, tell of the essence of the pain.

B: Look.

C1: Look.

C2: Very well. Isabel, tell me in what way can I serve you? What is happening with you?

D: She says that she has come again. Sometimes it [the pain / illness] makes her stomach swell at night and in the day.

C1: She says that she came to improve it [pain / illness]. The time before, she said—It is that the illness she has, has made another trip.

C2: Doctor, I am not able to say. Hee, hee.

Bar 2.

WS: Has made another trip.

B: I say, I arrived here once before. Yes, well, once more it [pain / illness].

C1: She says that she came to improve it [pain / illness].

C2: What is the nature of your pain?

D: What is the nature of your pain?

Bar 3.

WS: She says that she came to improve it [pain / illness]. The time before, she said—it's that the illness she has, has made another trip.

B: I say, I arrived here once before. Yes, well, once more it [pain / illness].

C1: She says that she came to improve it [pain / illness].

C2: What is the nature of your pain?

D: Very well. Isabel, tell me in what way can I serve you? What is happening with you?

Bar 4.

WS: She says that she came to improve it [pain / illness]. The time before, she said—it's that the illness she has, has made another trip.

B: I say, I arrived here once before. Yes, well, once more it [pain / illness].
Bar 17.

Yes, oh.

Put a probe in through the mouth in order to see what there is in the stomach. So then, this is not good. Well then, I am going to recommend

Mom, I want that there.

Bar 18.

I think that’s what has to be done with Isabel. Because if not, we are going to give medicine... she will be fine. And when she has taken the medicine, again she will not be well. So then, no, this is not good. Well then, I am going to recommend

Bar 19.

Want that there.

Bar 20.
Bar 13.

WS: Here.

Yes.

WS

B:

It's inflamed.

Yes.

C1:

No.

C2:

She didn't have it done.

D:

Oh, okay.

The issue is that it is very probable that she has something inflamed in her stomach. ... not a single exam? Or had an X-ray made? Yes, a series of gastro-(inaudible), an examination of various X-rays? Oh, no, no. It wasn't here.

B:

No.

WS

C1:

No.

C2:

Yes.

D:

Yes.

She didn't have it done.

Oh, okay.

Yes.

Bar 14.

WS: ... not a single exam? Or had an X-ray made? Yes, a series of gastro-(inaudible), an examination of various X-rays? Oh, no, no. It wasn't here.

B:

No.

WS

C1:

No.

C2:

Yes.

D:

Yes.

She didn't have it done.

Oh, okay.

Yes. Inaudible...
Bar 25.

WS: Alright, doctor. That's it?

B: Because if she does not go we are just going to be giving another medicine . . .

WS: Alright, then.

Oh, hm . . . alright.

Bar 26.

WS: Only, I'm only going to make you a little note for the outpatient consultation for the hospital. Sit for just a moment.

C2: wait, he said.

C1: Alright then. Alright, then. You've been served. Alright, doctor. That's it?

C2: No.

WS: Because if she does not go we are just going to be giving another medicine . . .

C1: Alright then.
Bar 21.

WS: ohh . . .

B: :WS

C1: :B

C2: :C1

D: but it's the same exam here, that they are going to give . . .

Bar 22.

WS: :WS

B: :B

C1: :B

C2: :C2

D: that she go to the hospital in order to speed this up so that they can do the exams.

Bar 23.

WS: :WS

B: :B

C1: :B

C2: :C2

D: a doctor that only specializes in the stomach. But this will be those that are called gastroenterologists.

Bar 24.

WS: :WS

B: :B

C1: :B

C2: :C2

D: only the stomach. only the stomach.

Bar 21.

WS: :WS

B: :B

C1: :B

C2: :C2

D: Oh. a doctor that only specializes in the stomach. But this will be those that are called gastroenterologists.

Bar 22.

WS: :WS

B: :B

C1: :B

C2: :C2

D: only the stomach. only the stomach. Oh.

Bar 23.

WS: :WS

B: :B

C1: :B

C2: :C2

D: a slip so she can go for an outpatient consultation at the hospital. She has to see a doctor that only specializes in the stomach.

Bar 24.

WS: :WS

B: :B

C1: :B

C2: :C2

D: because only her

Bar 23.

WS: :WS

B: :B

C1: :B

C2: :C2

D: only the stomach. because only her

Bar 22.

WS: :WS

B: :B

C1: :B

C2: :C2

D: in order to speed this up so that they can do the exams.

Bar 21.

WS: :WS

B: :B

C1: :B

C2: :C2

D: ohh . . .
Bar 7.

WS: Ah... chibi' b'ay aj je k'ax le tule' na' ch nuwach ri' na' ch. Kuna':

C: 

H: 

Bar 8.

WS: K'o veces le nupalaj je k'o b'an ni kariparatik e le waral, le waral je kub'an le ri' kujik rib'. Mhm. Y chi k'ut

C: 

H: Mhm...

Bar 9.

WS: kinb'ij le in k'ax knimajtajik kinch'a ri. Kwaj in le, le, komo inyección le ri ek'ia kitijik

C: K'o veces kuwar ta chaq'ab',

H: Mhm.

Bar 10.

WS: Ar ese eu, we ma, pero we ma are le nervio, le are le

C: kuwar ta, kuwar ta, k'o jun viaje kuwar ta chaq'ab'. Man kuwar taj.

H: Mhm.

Bar 11.

WS: le nujolom kq'oxowik, kq'axowik, kq'oxow nujolom. Pero tz'are le waral le jere tzij ketijik Kinco are ku' la le nertio.

C: 

H: Mhm.

Bar 12.

WS: o mare pa')

C: 

H: Areso, xawilo kus ka chik le nujolom.
Appendix C

Bar 1.

WS:
Ah . . . porese le nijolom kaq'oxowo k'ula' , kaq'aoxowik le nijolom y le wanima' le

C:

H:
S u kub'ano le apam, le ajolom?

Bar 2.

WS:
mi sm keq'oaq'anik y le nervio je kuqaj pa taq le waqan, pa taq nuq'ab' kajululik kpetik taqal che nijolom.

C:

H:
Mh hm . . .

Bar 3.

WS:
E k'ut, kaqaj pa taq nuq'ab' k'i karakaratik are k'u la le nervio. Parece nervio k'u la karakaratik je kub'an le ri,

C:

H:
Mhm. Mhm.

Bar 4.

WS:
ri' karakarat che le numpam. Qas uwach e k'o veces Klimnurrpa mikhail y k'z'inknir?

C:

H:
Y le kinb'ij in Juana . . . qas uwach . . .?

Bar 5.

WS:
Are je.

C:

H:
K'o veces qas e chjaq'ab' e . . .? Are la' le nervio kub'anowik kinche

Bar 6.

WS:

C:

H:
Are la' le nervio kub'anowik . . . com xa kula la a choq'ab' man k'o
Bar 19.

WS: ta wi

C:

H: Tres meses ruk' ne lo veinte días man xuwar ta o veinte cinco días xuwar taj.

Bar 20.

WS: Katij kunab'al atzij tu k'u la? Arese, xintijo. E, le, le, le, le, le, le, le, le naj wa, le

C:

H: Mhm hm. Xatij kunab'al at? Ah . . .

Bar 21.

WS: le naj wal man utz taj. Mhm. Pareso, xa are le pa jewa' le xa re mas niem are k'u naj kkayik xa na

C:

H: Ah . . . Su uyab' naj awal?

Bar 22.

WS: wich'. Ajor, paq'ina chi ri kajuk'uwik pero kajuk'uwik. K'o ta le

C:

H: J untire le waral chi le waral mucho le kub'ano le waral.

Bar 23.

WS: nuwaram chike la K'ia mul xink'am pik San Pedro. Utz le, le, le . . . le, le, le kpaq' cha aceite kutzira, kutzirik kinuchixik.

C:

H: Fanzikr wi fondo kajuk'uwik K'o te Le

Bar 24.

WS: Xa rumal tu wi Xa m xutzirij tu wi. Joropa, te ne kinkoj ketej che le man ko'ol ak'al. E xa m xuna' ta

C:

H: Xa Rumal tu wi Xa m xutzirij tu wi. Le ne Kinkoj, Ketej che le man ko’ol ak'al. E xa m xuna’ ta.
Bar 13.
WS: Kinsa chik pa mundo ti chik in k'o wi kino'o kusachisaj lem pero qas man kuchom man ti chik le nujolom kina in.

Bar 14.
WS: Xaq kusachisaj. Qas kumo k'u la le kub'ano a xaq ktz'in tz'iq'o le ktzeleb'ik qas k'u che k'u la?

Bar 15.
WS: La are k'a ruk'?

Bar 16.
WS: Ah, kuy a k'ax man kwar taj.

Bar 17.
WS: Tzij, k'u la koma xinan k'u le chi te mojog kexam le Jan lej wall. Kome K'o nei wall Xamal xal pa mundo...

Bar 18.
WS: e . . . ma ta k'u le, le, le kwar ta mata k'u xa kol kajib' ik' k'u la le, le xa k'o ta wi nuwaram una vez. Xa man k'o

APPENDIX C  171
Bar 31.
WS: Pareso chi ri' k'u la' cuand chi ri como jun junab' k'u la'le, le, le, le . . . le, le, le, le xel, le

Bar 32.
WS: xa'ano         E . . . xkamik.         E . . . wa ma naj ta xya che re ch'a jun q'ij. Jun aq'ab' xya' che re                                Xa.                   Sa ma

Bar 33.
WS: na j ta xa ma k'aslel taj.                                                                                                                                          Mhm.

Bar 34.
WS: Primer Viernes le xinmuqu y ya, y okanaq pa once meses Kaminak chik jun yab'il le . . .     le nab'e

Bar 35.
WS: Primer Viernes le xinmuqu y ya, y okanaq pa once meses Kaminak chik jun yab'il le . . .     le nab'e

Bar 36.
Bar 25.
WS:  
Ri k'u ne xok kan le nuyab' le  K'o ta le nuwaram . . .  
Kawaj kinwarik pero xa koma tzare xinwala le b'e pa le mundo.

H: Je, pues.

C: Mhm.

H: Mhm.

C: Ek'o ya veces jun viaje que ruk' va jun aq'ab' katkam rumal pa?

H: Areso.  
Mhm . . . Je, k'u la la we oxib' ik.

C: Areso k'u awib' ri' mismo.  
Xaq je la' xu k'aq k'u rib' la le nervious chawij.

WS: Areso xab'ij k'u awib' ri' euros.  
Xaq le la' xu k'aq k'u rib' la le nervious chawij.

H: Ji, ji, ji! Tzij ri' le kab'ij.

C: Xaq je la' xu k'aq k'u rib' la le nervious chawij.

WS: Areso k'u awib' ri' euros.  
Xaq le la' xu k'aq k'u rib' la le nervious chawij.

H: Areso xab'ij k'u awib' ri' euros.

C: Areso k'u awib' ri' euros.

H: Areso k'u awib' ri' euros.

C: Areso k'u awib' ri' euros.
Bar 43.

WS: Ah! J e k'u la kinb'ij ri in. Mhm. Areso:

C: Q'aq'

H: q'aq' taj. No, no, no . . . Mhm, le in le kunab'al le tajin kinkoj chawe man q'aq' taj.

Ni q'aq':

Bar 44.

WS: Areso. Xaq are chi ri k'ut kinb'ij wa in che nervios xaq k'ia kkojik ri in. Pero k'ia:

C:


Bar 45.


C: ...

H: je tzij. Mhm.

Bar 46.


C: ...


Bar 47.


C: ...


Bar 48.

WS: Are ne k'u la . . . le nuwach man gas ta k'ij ri mas Xaq mero kno' malk.

C: ...

H: Areso.
Bar 37.
WS: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.
C: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.
H: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.

Bar 38.
WS: Kinnum ta kachaqi'j ta nuchi' pero xa are le wani'na, kq'ayes are Kintij ta chik xaq kinrayij chik. Mhm. E... E... E... Axtro freso chik.
C: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.
H: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.

Bar 39.
WS: Le, pues. Kintij ta chik xaq kinrayij chik.
C: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.
H: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.

Bar 40.
WS: Le, pues como le
ta chik xaq kinrayij chik.
C: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.
H: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.

Bar 41.
WS: Agua pura. E... Kintij e E... Kintij ta chik xaq kinrayij chik.
C: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.
H: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.

Bar 42.
WS: Are Katadilink. No, uzi la chik dunka.
C: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.
H: Chik pa le nub'akil. E! va xay kyeb' uwach ketana' chi la jun. Are che k'u la le astritis chik vay le man.
Bar 49.
WS: K'o ta                                                       La, le, le chi majoq kkeje' wa?
C:                                                             
H: xatijo chi chi at yawab’ ruk’ la k’al?                       Doctor yowik o xaq xaloq’o?

Bar 50.
WS: Que xintatab’ej ne ri . . .         xintatab’ej ne ri          Ahh . . . pa clinica xinta’wi.
C:                                                             
H: ri majoq kkeje’ le ak’al.                                      Xatatab’ej ne ri.                                                  Mhm . . .  Tonces, je pues.

Bar 51.
WS: Inyección, e kyeb’ caja pastill xintijo’ .                                                                   No, majaqok.  Are k’u
C:                                                             
H: Inyección xa kojo'?                                                                              Pero ya at yawab’ chik o maja?

Bar 52.
WS: ne chi ri,  are kinwa kune’  xa  kink’iyisaj  are  le na jun. Kink’iyisaj ne wa’  kinche  ri como xaq  chi  ka  kab’  junab’ .  Xaq
C:                                                             
H: Mhm.                                        M hm                      .

Bar 53.
WS: chi ka kab’junab’ kuk’eje’ik.      E . . . xaq k’u kq’abar kitat.      E . . . le, le, le, le, a jor ch’uj kq’arik.                   Entonces, 
C:                                                             

Bar 54.
WS: kch’ayanik kkopanik kkixi’ij ku kib’                                                             No.
C: No, k’o ta chik.                                                  Ji, ji, ji! 
H: Pero ya al yawab’ chik o maja?
C:                                                             
H: rt majoy Kk’etle le ak’al.
C: xtentak el, xe pias.
H: Que xtentakt el . . . xtentak el Ahh . . . pa cintak qintak.

Bar 49.
WS: xalixo chi rt yawab’ ruk’ la k’al?  Doctor yowik o xaq xaloq’o?
C:                                                            
H: Ko te
C: L’a le chi majoy Kk’etle wa?
W
Bar 67.

WS: 
C: 
H: 

Pero no pase si hubo alguna falta o error.

Bar 68.

WS: 
C: 
H: 

¿A quién le va a inyección y le pastilla porque la amenaza parte utz pero la del que le ub'akil il está en su casa le.

Bar 69.

WS: 
C: 
H: 

¿A quién le va a inyección y le pastilla? ¿Le van a inyección y le pastilla también? ¿Le van a inyección y le pastilla tambien.

Bar 70.

WS: 
C: 
H: 

¿A quién le va a inyección y le pastilla? ¿Le van a inyección y le pastilla también? ¿Le van a inyección y le pastilla tambien.

Bar 71.

WS: 
C: 
H: 

Bien pero xaa le en kinitt la chicx.

Bar 72.

WS: 
C: 
H: 

¿A quién le va a inyección y le pastilla? ¿Le van a inyección y le pastilla también? ¿Le van a inyección y le pastilla tambien.

Bar 73.

WS: 
C: 
H: 

¿A quién le va a inyección y le pastilla? ¿Le van a inyección y le pastilla también? ¿Le van a inyección y le pastilla tambien.

Bar 74.

WS: 
C: 
H: 

¿A quién le va a inyección y le pastilla? ¿Le van a inyección y le pastilla también? ¿Le van a inyección y le pastilla tambien.
Bar 61.
WS: Xki xkkib'ij k'u la' pero xaq je'e xaq kinche la como kinta taj. Man kinch'ob' ta, qas tene' le qe.
C:
H: Ah.

Bar 62.
WS: le in ktz kixtzijon pa qach'ab'al. E kincholo da' qas kinb'ij tzij bien kinta como la' le kinta' ti in le castill. Xaq.
C:
H: Mhm hm.

Bar 63.
WS: k'u . . .
C: Va, la k'u, va ne la pero kuta joxil pero man kukwin taj.
H: Pero kukwin tu chub'ixik.

Bar 64.
WS: kinwin taj. Are k'u le mas kax na. Kax ne kachhop le castill.
C:
H: Bueno, de todos modos va xq'ax la' la are. Tonces, Are ma kinkwin tu che lub'ixik.Are ma k'ax ne kqach'ob' le castill.

Bar 65.
WS: Rajawaxik wa chanim que le katutzirik. Por eso xib'ij chawe le Lumil K'atuy K'dawaxik Kab'an ach'ab'la K'atuy le.
C:
H: Q ajawaxel Dios para que si katutzirik tambien y kata' sachb'el amak la che re la' xab'ano pero chub'anik tu k'u la.

Bar 66.
Bar 80.

WS: Naja lu wi che rech. Ji, ji, ji! Le man utz ta najal kujne. Misa k'o a qachin b'iinaq.

C: wi' che rech.

H: Je, pue s.

Bar 81.

WS: chuwe k'amik le k'u ri pa chin tag winaq keb'in chuwe. Le k'u la xinwil. Le ko chik, Mo k'o ak'al chi, La...

C: wi che rech.

H: Tonce kakojo b'ik le akunab'al? Ta bueno.

Bar 82.

WS: chuwe k'amik le k'u ri pa chin tag winaq keb'in chuwe.

H: Je.

C: Le pues.

H: ki le b'ik.

Bar 83.
Bar 73.

WS: como katit le a Xper chuwi' Juyub'. La katchobo? Mhm.

C: Sí, le k'o pa le parroquia.

H: Ah! La at ri ra at rilib'. Ah.

Bar 74.

WS: mism k'u ri le xa k'o kunab'al xatijo wene xa k'o pastilla che ri je xub'an ak'al le le' keche ri chuwech.

H: Ah.

Bar 75.

WS: kinta re in man utz ta le akalb' kul kamik che. Ma xa we xa k'o wuch la t'um che. Keche ri pero qas kinb'an chik in k'o chik chumpam.

C: E... tzij ek'o keb'inik wene eclipse kuchiklak. K'o kib'inik wene xak'aj tumal ak'o k'o.

H: Je, pues.

Bar 76.

WS: kib'inik wene xa tew. K'o ta kb'ixik.

C: Es que le jun nuito ya man entereo ti chik. Chi ri xam le kam narc pa?

Bar 77.

WS: le Lunes. Ah tzij k'u la, man utz ta kilik.

C: Chi ri chawech, kin'ij chawech a jor je keche ri paschill che ri xub'an ak'al le le' naj ak'al.

H: Man utz ta kilik.
Bar 7.

WS: Oh . . . here it is a lot, and much . . . Yes, my face hurts and feels painful here in front. It feels

C: absent. Then, for this reason it does ring.

H: absens. Then, for this reason it does ring.

Bar 8.

WS: that at times my face. Yes, there is also something that makes it twitch. And here, here it makes this part pull. Yes. And for this reason

C: There are times that she does.

H: That's right, if, if not, but if it is not nerves, then it throws itself towards the head. Then, it throws itself towards the head.

Bar 9.

WS: I say that the pain has worsened, I tell you. I want like the, the, the injection for the tremendous pulling sensation.

C: There were times that she didn't sleep. There was a time that she did not sleep at night. She doesn't sleep.

H: That's right, if it is not, but it is not nerves, that thing.

Bar 10.

WS: hurts my head, it hurts my head. But this right here, truthfully, it feels like the pain had been eating me. Because of the nerves or

C: not sleep at night, she doesn't sleep. There was a time that she did not sleep at night. She doesn't sleep.

H: Yes . . .

Bar 11.

WS: I say that the pain has worsened. I tell you. I want like the injection for the tremendous pulling sensation.

C: There were times that she doesn't sleep. There was a time that she did not sleep at night. She doesn't sleep.

H: That's right, if it is not, but it is not nerves, that thing.

Bar 12.

WS: maybe not. That's right, I saw it just separating / splitting my head. That's right, because of nerves. Then, it throws itself towards the head.

C: not sleep at night, she doesn't sleep. There was a time that she did not sleep at night. She doesn't sleep.

H: Yes. . .
Bar 1.

WS:

Uh . . . well, my head hurts with sustained pain, my head hurts, and like my spirit:

H:

What is the essence of what your stomach is doing, and your head?

C:

Ye...Yes. Hm. Yes, is that what she hears?

WS:

Yes, they burn. And the nerves.

H:

Ye...Yes, those times are tight. It burns. It burns and leaves this area as if there were now silence there.

C:

Yes, that's right.

WS:

That's it.

Bar 2.

WS:

Tha...Then, it descends to my hands, constantly scratching. This is because of nerves. Then, it's nerves.

H:

There are times that it leaves this area in my ear and it hurts.

C:

Yes. Hm. hm. Hm. hm. Hm. hm.

WS:

This, this. Scratching my stomach.

Bar 3.

WS:

They burn. And the nerves. Yes, they dropped to my feet and to my hands, burning like being next to fire and coming directly to my head.

H:

Yes.

C:

That's right. Only nerves do this, I say.

WS:

Yes, yes.

Bar 4.

WS:

This is the constant scratching it makes. Look, I say...

C:

And I say, Juana . . . what is the essence. . . ?

H:

Yes, hm.

WS:

What is the essence? There are times that it leaves this area in my ear and it hurts.

Bar 5.

WS:

Tha... That's right, only nerves do this, I say.

C:

Ye...Yes, only a fever, only nerves do this, I say.

H:

Yes, yes.

WS:

That's it.

Bar 6.

WS:

Tha...That's right, only nerves do this, I say.

C:

Ye...Yes, only a fever, only nerves do this, I say.

H:

Yes, yes.
Bar 19.

WS: It's true, because the child arrived here in the world deformed. The child slept for twenty days with the child she didn't sleep or twenty-five days she slept not.

C: Sleep for me, various times. I took them to San Pedro. It's good if the, the, the, the, the, the, the, the problem breaks. It's said that oil heals it. They told me it heals.

WS: That's right, I drank it. Uh, the, the, the, the, the, the, the, the little boy. It pulls, but you pull . . .

C: Everything around here, here, a lot was done here. Everything was done here. Yes... What was the essence of your little boy's illness?

WS: Yes, hm . . . You drank medicine? For that reason, just like this, only a small part in front of the face. There was not.

C: Of mine wasn't well. Yes.

WS: Reason is because I drink medicine. Is that true?

C: Reason is because I drink medicine. Is that true?

WS: Yes. Reason is because I drink medicine. Is that true?

C: Reason is because I drink medicine. Is that true?

WS: Three months. For twenty days with the child she didn't sleep or twenty-five days she slept not. It's true, because the child arrived here in the world deformed. The child.
Bar 13.
WS: I just lose my knowledge in the world, not just where I am. I feel the world is lost to me but not just my thoughts. I feel my head is lost. It just makes me forget.
C: In what way, then, does just the ringing cause damage, what then about the ringing?
H: It's true because it did this, because it's like when my small son was not yet dead. Like I had a son, he was a twin. He arrived in the world.
Bar 17.
WS: Oh, it causes hurt when there is no sleep?
C: Does this to you... Then, yes, they have caused you hurt. You think too much. Then, if you don't sleep the thoughts gather, and all of them together take away strength.
Bar 15.
WS: It's for that reason?
C: Does this to you... Then, yes, they have caused you hurt. You think too much. Then, if you don't sleep the thoughts gather, and all of them together take away strength.
Bar 18.
WS: Lik3 nearly
H: Oh...
C: Yes, hm. You think too much. Then, yes, they have caused you hurt. You think too much. Then, if you don't sleep the thoughts gather, and all of them together take away strength.
Bar 31.

WS: That's right, for this reason because like one year then, the, the, the, the, the, the child left, it

C: do not sleep and that's it, it happens even more.

Bar 32.

WS: was done. Yeah . . . he died. Huh . . . if he had not have been small, on a day he was given, a night he was given. Only. Not much

C: it is. Yes. Only a day. Yes.

H: The first Friday he entered the world and already, today just makes eleven months since the illness has entered. . . . The first

WS: How long did you say, a month. . . . your son entered the world? The first Friday then. True it was then. The time, his life was not meant to be.

C: First Friday?

H: Yes.

WS: The first Friday he entered the world and already, today just makes eleven months since the illness has entered. . . . The first

C: The first Friday then. True it was then. The time, his life was not meant to be.

H: Yes. Yes.

WS: Oh . . . only a day. Yes.

C: It is. Yes. Yeah . . . he died. Huh . . . if he had not have been small, on a day he was given, a night he was given. Only. Not much.

WS: was done. Yeah . . . he died. Huh . . . if he had not have been small, on a day he was given, a night he was given. Only. Not much.
Bar 25.
WS: For this reason, my illness entered and stayed. There's no sleep for me... I want to sleep but because I opened the road to this world.
C: Ha, ha, truth! It's for certain what you say.
H: That's right.
WS: Bar 30.

Bar 26.
WS: from there it started. There is just no sleep for me. Here is why my illness entered, I tell you. Like, my sleep.
C: There... one he felt the world... But only only only. Only his head was small. Jesus, it's true that I made food for him of this I speak.
H: Yes, of course. Here it is of course. Next, I saw my children. Yes, the poor little.
WS: Bar 29.

Bar 27.
WS: arrived. Here is why my illness entered. I tell you. Here is why my illness entered. I tell you.
C: Like my sleep.
H: Yes. For this reason you nearly scared your own self. For this reason, Il hit you. The nerves came over you.
WS: Bar 30.

Bar 28.
WS: There are now times, one time that with the passing of night you were taken by it, right? That's right. Yes.
C: Yes. for that reason. Three months.
H: That's right.
WS: Bar 27.

Bar 29.
WS: Yes, of course. Here is of course. From there it started. There is just no sleep for me. Here is why my illness entered. I tell you.
C: Like my sleep.
H: Yes. For this reason, my illness entered and stayed. There's no sleep for me... I want to sleep but because I opened the road to this world.
Bar 43.
WS: Oh! I think yes, it is not hot. For sure.
C: Yes, it's not hot.
H: Yes, it's not hot.
WS: Yes.

Bar 44.
WS: It is only when I say that it is because of the nerves, they just administer much more. I say: It boils. Your stomach. Like when you drink and it rises to my head.
C: That's true. Yes.
H: Yes.
WS: It does not make me happy; the drunkenness. Yes. It makes the world spin. Yes.

Bar 45.
WS: It is. Much more. I think that the maximum. I tell you. The most there is. Lh... it will cure my stomach. Like when you drink and it rises to my head. Of course.
C: Of course.
H: Four of five to be administered.
WS: It is. Much more. I think that the maximum. I tell you. The most there is. Lh... it will cure my stomach. Like when you drink and it rises to my head.

Bar 46.
WS: I do not make me happy; the drunkenness. Yes, it makes the world spin. Yes.
C: Yes.
H: Yes.
WS: She wants to you.
C: To you.
H: Yes, him.
WS: Yes.

Bar 47.
WS: The debility. It is... My eyes, they no longer see. I only see like a cloudy view.
C: Yes.
H: For sure, it is the debility that does that.
WS: Yes.
C: It does not make me happy; the drunkenness. Yes. It makes the world spin. Yes.

Bar 48.
WS: It is. Much more. I think that the maximum. I tell you. The most there is. Lh... it will cure my stomach. Like when you drink and it rises to my head.
C: Of course.
H: Four of five to be administered.
WS: It is. Much more. I think that the maximum. I tell you. The most there is. Lh... it will cure my stomach. Like when you drink and it rises to my head.

Bar 49.
WS: The debility, it is... My eyes, they no longer see. I only see like a cloudy view.
C: Yes.
H: It is not hot.
WS: Yes.
C: Yes, it is not hot. No, no. It is only when I say that it is because of the nerves, they just administer much more. I say: It boils. Your stomach. Like when you drink and it rises to my head.
H: Yes.
WS: Yes.
C: Yes.

Bar 50.
WS: It is. Much more. I think that the maximum. I tell you. The most there is. Lh... it will cure my stomach. Like when you drink and it rises to my head.
C: Of course.
H: Four of five to be administered.
WS: It is. Much more. I think that the maximum. I tell you. The most there is. Lh... it will cure my stomach. Like when you drink and it rises to my head.
Bar 37.
WS: pain all about my body. Uh, well, it was two forms of pain that the one pain suspends. This is just because of gastritis.
C:
H: Yes, hm. Yes, of course.

Bar 38.
WS: All right then, I am not hungry nor does my mouth thirst. Only my chest burns, it burns. Yes, it is true. I feel wounds, it
C:
H: It burns. Yes. Yes.

Bar 39.
WS: does not want me to eat tamales. I just don't eat. I only desire to eat. Yes, of course like the... I eat uh... the, the, the, the, just those many vegetables... I only wants to drink. Yes, I just cannot eat. My body wants... It only wants to drink. Yes, of course. Does not want me to eat tamales.
C:
H: Yes, of course. Like the... I eat uh... the, the, the, the, just those many vegetables... I only wants to drink. Yes, I just cannot eat. My body wants... It only wants to drink. Yes, of course like the...

Bar 40.
WS: purified water. Uh... I eat uh... the, the, the, the, just those many vegetables... I only wants to drink. Yes, of course. Those that you pick. Yes.
C:
H: Yes, of course. Like the... I eat uh... the, the, the, the, just those many vegetables... I only wants to drink. Yes, of course. Those that you pick. Yes.

Bar 41.
WS: For sure, but is the injection hot?
C:
H: On clothes that, eat them and in addition to that, an injection will be administered in order to... For sure, but is the injection hot?

Bar 42.
WS: Yes, of course. Of course. No, that's good. Keep on
C:
H: Yes, of course. Like the... I eat uh... the, the, the, the, just those many vegetables... I only wants to drink. Yes, of course. Those that you pick. Yes.

Bar 43.
WS: All right then, I am not hungry nor does my mouth thirst. Only my chest burns, it burns. Yes, it is true. I feel wounds, it
C:
H: Yes, of course. Like the... I eat uh... the, the, the, the, just those many vegetables... I only wants to drink. Yes, I just cannot eat. My body wants... It only wants to drink. Yes, of course like the...

Bar 44.
WS: does not want me to eat tamales. I just don't eat. I only desire to eat. Yes, of course like the... I eat uh... the, the, the, the, just those many vegetables... I only wants to drink. Yes, I just cannot eat. My body wants... It only wants to drink. Yes, of course like the...
C:
H: Yes, of course. Like the... I eat uh... the, the, the, the, just those many vegetables... I only wants to drink. Yes, I just cannot eat. My body wants... It only wants to drink. Yes, of course like the...

Bar 45.
WS: purified water. Uh... I eat uh... the, the, the, the, just those many vegetables... I only wants to drink. Yes, of course. Those that you pick. Yes.
C:
H: Yes, of course. Like the... I eat uh... the, the, the, the, just those many vegetables... I only wants to drink. Yes, I just cannot eat. My body wants... It only wants to drink. Yes, of course like the...
Bar 55.

WS: He's not here. He went to the United States.

C: No . . . ha, ha!

C:

H: He's not here.

C: He went to the United States.

WS: Oh, I thought . . . that he was dead. Ha, ha, ha.

WS: He's not here.

C: He went to the United States.

WS: No . . . ha, ha!

H: Well, they discussed it but still I just did not understand much Spanish . . . not very well.
Bar 49.
WS: There is none . . .
C: The, when my son wasn't yet born?
H: The doctor gave it to you or did you buy it? Yes,
WS: The, the, the, the strong anger that he has when he drinks.

Bar 50.
WS: I'm not sure I recall.
C: Yes. Yes.
H: Child every two years. Uh, only, well, their father drinks. Uh . . . The, the strong anger that he has when he drinks.

Bar 51.
WS: An injection, and I took two boxes of pills.
C: Not at that point. My desire was for one child to grow up before having the next child. I say, I have a child and like I should only have another child every two years. Only another.
H: Yes.

Bar 52.
WS: But you were already pregnant or not?
C: An injection, and I took two boxes of pills.
H: Yes of course. Then yes you recall.
WS: When your son was not yet born. You're not sure you recall.
C: I'm not sure I recall . . . I'm not sure I recall. Oh! It was in the Health Center.

Bar 53.
WS: He arrives and he hits and scares them.
C: No.
H: But is he there now? Ha, ha, ha!
WS: He recently died or . . . ?
C: Ha, ha, ha.

Bar 54.
WS: No, now he's not there.
C: Ha, ha, ha.
H: The, the, the, he and scares them. No.
Of course, it's true that you want to leave a space between having children, but maybe they didn't say anything to you about the hurt caused by the cause.

Bar 68.

Ha, ha. Has only take the medicine. Because they have a part that is good and a part that is bad. They cause hurt to the body of a woman and it burns.

Bar 69.

Ah, that's right. Is the injection hot?

Well, prayers only and I won't take the medicine. The thing is, Well, prayers only cure because of the medicine are hot. Many women for this reason, who are given womb cancer because of the medicine. Well, it does cure. Many women, for this reason, who are given womb cancer because of the medicine.

Bar 70.

The stomach, the same thing that you feel. It's the same. Is the injection hot? Ah, that's right.

Bar 71.

Of course it's true that you want to leave a space between having children, but maybe they didn't say anything to you about the hurt caused by the cause.

Bar 72.
Bar 61.
WS: They say, they said it is fine but only that it is good, but because I didn't understand. I didn't understand, it's not like it is with us.
C:
H: Ah. You did not understand.
WS: They say, they said it is fine, but only that it is good, but because I didn't understand, it's not like it is with us.
C: You did not understand it.
H: What is needed now is for you to be healed. For this reason, I said to you the time before. You need to make your prayers. You ask our Supreme.
WS: I can speak in K'iche'. I can tell the story, I say the truth and I understand it when it's said because I do not understand Spanish. Only.
C: Well it's, well, but she understands a little bit but she can't... I can't do it. I cannot clearly, that's why.
H: I can't do it. That's why it's more difficult. It's a little difficult when we don't understand Spanish.
C: But she cannot affirmatively, only request.
WS: I can't do it. That's why it's more difficult. It's a little difficult when we don't understand Spanish.
H: What is needed now is for you to be healed. For this reason, I said to you the time before. You need to make your prayers. You ask our Supreme.
WS: I can speak in K'iche'. I can tell the story, I say the truth and I understand it when it's said because I do not understand Spanish. Only.
C: Well it's, well, but she understands a little bit but she can't... I can't do it. I cannot clearly, that's why.
H: I can't do it. That's why it's more difficult. It's a little difficult when we don't understand Spanish.
C: You all speak in K'iche'. I can tell the story. I say the truth and I understand it when it's said because I do not understand Spanish. Only.
WS: They say, they said it is fine but only that it is good, but because I didn't understand, it's not like it is with us.
C: You did not understand it.
H: Ah. You did not understand.
WS: They say, they said it is fine but only that it is good, but because I didn't understand, it's not like it is with us.
Bar 79.

WS: Then, maybe I was pregnant and because of that . . .

C: Far away from the body / funeral. Ha, ha, ha! It's not good to be close. We hid ourselves.

H: Yes, . . .

WS: That . . . that I already found dead there. For sure, you all administer it, right?

Bar 80.

WS: From far away I was looking, I said it's okay. They / funeral went by and because I didn't know. There was not any who had.

C: Far away from it.

H: Yes.

WS: I told me the effect of death, what happens when some people walk in front of you. Yes, I already saw it. It already happened. Poor little child.

C: Yes.

H: For sure.

WS: From far away I was looking. I said it's okay. They / funeral went by and because I didn't know. There was not any who had.

Bar 81.

WS: . . .

C: Yes.

H: Far away from it.

WS: Then, maybe I was pregnant and because of that . . .

C: We hid ourselves.

WS: Then, maybe I was pregnant and because of that . . .
Bar 73.

WS: Like the grandmother of Talin in Xela. You know about that?

Yes. For sure.

C: Yes, she was in the parish.

H: Yes.

Bar 74.

WS: it is the same, it was medicine that you took. Maybe it was pill that did it to the child. This is what she said to me. She says, that I feel

C: Oh.

H: That's right.

WS: Thats right. Yes, it is true there are those who say, maybe it is because of the eclipse. Maybe there are those who walk and pass illnesses by.

C: My uncle hes incomplete and when he died the body went past.

WS: witchcraft. Catch the soul or maybe there are those who walk and cold . . . . They don't say it.

Bar 75.

WS: the child will not arrive well, it will be dead. She said. Not only this, maybe it was what the child had eaten, she said. But what can I do now, I had the child inside.

C: It's that . . . My uncle he's incomplete and when he died the body went past?

WS: But what can I do now. For sure.

H: That's not good.

Bar 76.

WS: the Monday. When it was in front of you, I said it's better if we do it because of the uncertainty, the baby needs to be far away.

Oh true, it's not good to see the dead.

C: The Monday.

WS: The Monday.

Bar 77.

WS: witchcraft. Catch the soul or maybe there are those who walk and pass illnesses by.

H: Thats right.

C: Yes.

WS: Thats right.

Bar 78.

WS: the Monday. The same, it was medicine that you took. Maybe it was pill that did it to the child. This is what she said to me. She says, that I feel

C: You are her daughter-in-law.

WS: Like the grandmother of Talin in Xela. You know about that?

H: Yes, she was in the parish. You know about that?
Bar 7.

WS: 

cada ocho horas.

N: 

Va tomar una cada ocho horas. Sí. Tiene que terminar esas pastillas. Hoy mismo le voy a empezar a poner una de esa inyección.

Bar 8.

WS: 

Ah.

N: 

Ah... vaya.

Puede que no tenga almohada en su cabeza, pero que no usele. Éste son de Piroxicam. Esto le va a ayudar bastante a quitarle ese dolor.

Bar 9.

WS: 

bien.

N: 

Sí. Estas son de Piroxicam. Esto le va a ayudar bastante a quitarle ese dolor. Sí.

Bar 10.

WS: 

Dura.

N: 

Puede que no sea tan importante estar bien de inyecciones aparte de la medicina. De que usted haga su reposo. Tiene que acostarse en una cama dura. Que no sea algún aparte de la medicina.

Bar 11.

WS: 

Ah.

N: 

Ah... vaya.

Oye, le va a servir para el dolor. Puede que no tenga almohada en su cabecera para que usted. Este totalmente recto y pueda descansar bien su cuerpo. Sí?

Bar 12.

WS: 

Entonces, yo ahora le voy a poner una de esa inyección.
Bar 6.

N: ¿Para qué esto? Podemos estar cargando la vida, estar haciendo el trabajo muy duro. ¿Es por mucho trabajo pesado? Vamos a ver si eso ocasiona el dolor que usted tiene y que no le pasa.

WS: Sí.

Bar 5.

N: Pues, todo el día estar cargando bultos, estar trabajando mucho, mucho trabajo, mucho esfuerzo. ¿Puede este esfuerzo, verdad que usted tiene, ocasionar el dolor que tiene y no le pasa?

WS: Sí.

Bar 4.

N: El esfuerzo muy brusco y entonces, que dolor que ahora tiene y no le pasa, verdad? Entonces, lo que usted tiene que hacer es tener más cuidado. No levantando cosas pesadas y no estarlo haciendo así muy seguido.

WS: Sí.

Bar 3.

N: Todo el día estar cargando bultos, estar haciendo mucho trabajo, muy forzado. ¿Sí?

WS: Sí.

Bar 2.

N: Para este dolor que usted tiene, se le va a dejar esa medicación. Va tomar un pastilla de este biclofenaco.

WS: Sí.

Bar 1.

N: Es un dolor que usted tiene, se lo va a dejar. Va a tomar una medicación. Va tomar un pastilla de este biclofenaco.
Bar 19.

WS: ¿Dónde me van a poner la vacuna, disculpe? ¿En el brazo?

N: Sí, la vacuna pasada por circon diés. Vaya.

WS: Vaya.

Bar 20.

WS: Ah, ya.

N: Sí. Diga, su cadera. Entonces, sí lo quedar va a tomar sus pastillas y vaya, verdad? A ver, dígamelo, como se las va a tomar.


WS: Vaya.


WS: Vaya.

Bar 19.

WS: ¿Dónde me van a poner la vacuna, disculpe? ¿En el brazo?

N: Sí. Sí.

WS: Vaya.

Bar 19.
Bar 13.

_WS:

---

N: También, le toca su vacuna. Esa vacuna es contra el tétano yo no sé si usted ha oído . . . esta enfermedad de que causa

_WS:

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Bar 14.

_WS:

Sí. Sí, porque me han vacunado desde mi niñez. Ji, ji, ji. Ya, no el tétano. ¿Verdad? Entonces para

_N:

Y o se que . . . Ah . . . bueno. Entonces, le voy a poner una primera ahora contra el tétano porque

_WS:

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Bar 16.

_WS:

---

N:

---

Bar 17.

_WS:

---

N:

---

Bar 18.

_WS:

Hm. hm.微 robio que es el tétano. Sí? Entonces, le voy a poner su primera vacuna, y aparte le voy a poner la primera

_N:

---

Bar
WS: Every eight hours.

N: biclophenac. You're going to take one every eight hours. Yes. You have to finish those pills. Today, I'm going to administer one portion of that injection.

WS:

N: Wooden bed that you sleep on. Right? And that you don't have a pillow under your head. So that you are totally straight out and can rest your body. Yes? Well, now I am going to administer one portion of that injection.

WS:

N: begin to administer these injections, which are going to be useful for the pain. The most important, also, apart from the medicine is that you take your rest break. You have to lay down on a hard bed, hard, like so. That it's not a wooden bed that you sleep on. Right? And that you don't have a pillow under your head. So that you are totally straight out and can rest your body. Yes? Well, now I am going to administer one portion of that injection.

WS:

N: These are Piroxiccan. This will help a lot to remove that pain. Yes, But the most important also, begin to administer these injections, which are going to be useful for the pain. Well, I'm going to administer one daily.

WS:

N: That's fine. These are Piroxiccan. This will help a lot to remove that pain. Yes. But the most important also.

WS:

N: Behind the medicine is that you take your rest break. You have to lay down on a hard bed, hard, like so. That it's not a wooden bed that you sleep on. Right? And that you don't have a pillow under your head. So that you are totally straight out and can rest your body. Yes? Well, now I am going to administer one portion of that injection.
Appendix F

Polyphonic Score

Bar 1.

Yes.

Bar 2.

Then, what? That pain you now have and is does not pass, right?

N: Yes.

WS: Okay.

Bar 3.

But this is the consequence of a lot of heavy work. Still, it was

N: Uh... Okay.

WS: Well.

Bar 4.

N: But not all heavy things and do not engage in doing this very frequently, of course.

WS: Yes.

Bar 5.

N: For that you have to do is to be more careful. Do not lift heavy things and do not engage in doing this very frequently, of course.

WS: Yes.

Bar 6.

N: That's what you have, sir. What you have, sir is a strained lumbar. That is to say, it is the pain right that have you have, sir.

WS: It's a...

...
| Bar 19 | WS | Excuse me, where are you all going to put the vaccine? In the arm? |
| Bar 20 | N | Going to administer your first injection to remove a little and... |
| Bar 21 | WS | Uh, yea. Yes. |
| Bar 21 | N | If you desire going to administer your first injection to remove a little and... |
| Bar 22 | N | Going to put the vaccine in the arm? Okay. Yes. |
| Bar 22 | WS | Yes. Tomorrow and one the day after tomorrow for five days. |
| Bar 22 | N | Yes. Every eight hours. And your injection? Yea, one. |
| Bar 22 | WS | Yes. Yes. |
| Bar 22 | N | Yes. Yes. Let's see, tell me how are you going. |
| Bar 22 | WS | Daily. That is one. Yes. |
| Bar 22 | N | I'm going to take some pills every eight hours. Yes, one. |
| Bar 22 | WS | Yes. Yes. Yes. Okay. |
| Bar 22 | N | Yea. Well, you remember to take your pills. Right? Yes. Okay. |
Bar 13.

WS: Also, it's your turn for a vaccination. That vaccination guards against tetanus. I don't know if you've heard...

N: So, it's your turn for a vaccination. Yes?

WS: Well, I am going to administer your first vaccination and aside from that I'm also going to remove a molar.

Bar 14.

WS: Oh, that is the vaccination. Yes, that's very good. Right?

N: That is, if you get hurt or sometimes there is a cut. Right? By having a vaccination because you are working in the fields. Of course, if you get hurt or sometimes there is a cut. Right?

WS: Yes.

N: Caution, because you are working in the fields. Of course, if you get hurt or sometimes there is a cut. Right?

WS: Yes.

N: I know that... Oh, all right. Well, now I am going to administer the first against...

WS: I don't have it because now... many years have passed.

N: I don't have it because now... many years have passed.

WS: There is... in short, there are various... forms of. If one can have a cut and there easily it can enter that...

N: That is... in short, there are various... forms of. If one can have a cut and there easily it can enter that...

WS: Hm... mic... that is... in short. Right?

N: Well, now I am going to administer your first vaccination and aside from that I'm also going to remove a molar.

WS: Hm...
NOTES

PROLOGUE
1. There is some discussion as to whether the prefix in “dialogue” is “dia-,” meaning “through,” or its cognate “di-,” meaning “two,” but whichever is etymologically accurate, the “di-” contributes to its association with an interaction between two parties.
2. Meaning does not exist in the language (or given text) but exists in (and is produced by) language users as a synthetic and integrative process of intellect and reason.
3. “Logos” is defined in this study as words, speech, discourse, and reason.

INTRODUCTION
1. The term “wellness seeker,” anthropologically defined here, is used to socioscientifically describe and differentiate between the social roles of individuals and or groups experiencing illness and undergoing (or who have undergone) remedial action within a therapeutic (nonbiomedical) context from those typically referred to as “patients” experiencing illness and undergoing treatment within a biomedical or clinical context. The juxtaposition of the terms “wellness seeker” and “patient” in this work stresses the possibility and existence of radically different human experiences of wellness, illness, and caring for the sick.
2. I refer to “ethnographic inquiries” rather than “interviews” following the work of Charles Briggs (1986), who points out the problems and presuppositions involved in utilizing interviews as a would-be acultural (universal) way of effectively gathering information.
3. The K’iche’ Maya term “ajq’ijab’” (the plural form of “ajq’ij”), which contains the prefix “aj” interpretable in English as “doer of” or “to be of” and the noun “q’ij,” meaning both “sun” and “day” (and perhaps “light”), has been most commonly represented (though sometimes contested) in ethnography as “shaman,” a term whose socioscientific etymology can be traced to Siberia (for a notable exception in the interpretation of “ajq’ij” see B. Tedlock 1992). The various meanings of “ajq’ij” and what constitutes its acceptable translations are evolving rather than fixed. My interpretation attempts to convey a sense of the Maya social role of ajq’ij as both shaman and day priest (with reference to the Maya calendar). Doing so means invoking the meaning and sense of “ajq’ij” not only as a doer of light or
keeper of days but equally importantly as a mediator between the sacred and the secular, in all of its varied forms and with all of its Maya ceremonial accompaniments.

4. The decision to modify standard K’iche’ orthography when attempting to reflect variations in participants’ ways of speaking was chosen over the use of say, the international phonetic alphabet, because Maya orthography makes the data more accessible to a broader audiences beyond linguists.

CHAPTER 2

1. “Negative capability” is a phrase used by Keats in a letter to his brothers George and Thomas (dated December 21, 1817) to describe the quality of those in possession of the ability to “be in uncertainties, mysteries, doubts, without any irritable reaching after fact or reason” (cited by Cuddon 1991:539–40).

2. By “homophonic analysis” I mean an approach to ethnographic and linguistic data that establishes authority and legitimacy via the same voice, the single voice of an author that ritualistically “fixes” the indeterminacy of the multiple voices and pluralistic experiences that populate recordings, recollections, and experiences in order to present a singular (monologic) discussion that is apparently seamless.

3. This is, perhaps, an extension of what Hall (1990) identifies as a Western proxemic style, culturally produced physical spaces that mediate social interactions and relationships.

4. My use of the term “simultaneity” in communicative interactions does not simply refer to occurrence of simultaneous speech but also to the simultaneous and cooperative co-occurrence of speaking and making communicative silence (as I discuss in the second part of chapter 4).

5. When the original work for this study had concluded with the completion of my doctoral dissertation, it was brought to my attention that Deborah Cameron, in her study entitled “Working with Spoken Discourse” (2001) had also experimented with a horizontal transcript, “a score layout.” The methodology of the polyphonic score put forth here differs significantly from Cameron’s in that it grows out of a wider approach that I term the “ethnography of polyphony,” which approaches communicative interactions as unfolding and as composed of the communicative contributions of interactants’ speaking as well as of their “communicative silences.” In addition, though I developed the polyphonic score independent of Charles Briggs (1993), who utilized a musical transcript to analyze Warao women’s wailing, I acknowledge the similarities in approaches and recognize his work is nothing short of a methodological watershed for the study of multivoiced interactions.

6. As in a musical score, the staff in the polyphonic score consists of a series of parallel lines. However, whereas in a musical score notes are placed on the lines or in the spaces between the lines, in a polyphonic score the communicative actions and contributions of interactants are placed only in the spaces between the lines of various staves.
7. The evidence for such relationships (in this case social status) is not to be found in a linguistic form, a given code, or speech itself but rather within the wider context of the community (D. Hymes 1962).
8. Goffman describes “ratified” interactants as those a) who participate in an interaction but who are not specifically addressed or b) who are addressed and are oriented toward the speaking in a manner that suggests that the speaker’s words are particularly for them (1981:9–10).
9. Though the terms “speaking” and “speakers” are used here, the polyphonic score also represents the unvoiced communicative acts of those not speaking.
10. The exception here is the first speaker to speak in a staff.

CHAPTER 3

1. In Guatemala the term “aldeas” is used to refer to small outlying villages or hamlets surrounding a municipio (township).
2. The quantity of speech needed to express an idea in K’iche’ and in Spanish is not equivalent to the quantity needed to express the same idea in English. The score, therefore, containing the English translations of the interactions is necessarily only an approximation of the original, which more accurately represents the interactions. Note that in order to distinguish interactants use of K’iche’ from their use of Spanish, the English translation of the K’iche’ in the figures is italicized.
3. The use of “first” and “second” in reference to the companions does not indicate the closeness and/or the importance their relationship to the wellness seeker but is rather simply a way of noting and distinguishing that the wellness seeker has two companions present. The baby in this clinical encounter was five years old. The child is included in the polyphonic score not because of her presence in the consultation but rather because the social role of child in Nima’ is that of a potential contributor to the curative interaction. As is discussed elsewhere, Goffman calls such interactants in a communicative interactions “ratified” participants (1981).
4. The decontextualizing affects of sentence-by-sentence analyses is a reference to the degree to which linguistic notations that exclude context (albeit inadvertently) can and do differ from what Moerman (1988) terms “contexted” conversation, that is to say, living interaction (see Duranti and Goodwin 1992). This decontextualization in analysis is perhaps most apparent when linguistic notations (utilized in describing findings) make reference to utterances in a transcript without implicating the larger sociolinguistic scene in which an utterance unfolds. Moerman provides the following example of “successive repair initiators” that illustrates this point “S, at line #42, explicitly (with the /nân/) repeats his earlier (line #6) reference form; S’s wife (at line #43) adds Nˇò-’s eponym” (Moerman 1988:21).
5. All names of the participants in the investigation have been changed.
6. The practice of doctor-initiated communicative interactions in biomedical
encounters is, as numerous studies in linguistic anthropology suggest, a characteristic of Western biomedical health. By “Western biomedical care,” I refer what Gaines and Hahn (1985) call “biomedicine.”

7. Ethnographic transcription and annotation of recorded materials was undertaken while at the field site.

8. By this I am suggesting that well-formed sentences, as unmarked, tend to not draw the same degree and kind of attention to the speaker as ill-formed sentences do. Following this view, well-formed sentences are more likely to “say,” involving listeners/receivers in the referential what of that which is being said, while ill-formed sentences are more likely to “show” or index, involving the listeners/receivers in the how and the who of speaking.

9. While Labov’s sociolinguistic definition of narrative in his study of black English vernacular (1972) informs my understanding of narrative, the term “illness narrative” is Kleinman’s (1988). Moreover, the chronologically structured narrative model Labov describes, featuring discernible abstract, orientation, complicating action, evaluation, result or resolution, and coda, is perhaps too overdetermined to be applied to Maya narratives (illness and otherwise). As Tedlock points out, a K’iche’ narrative “does not move strictly forward along the path of its events, but always gets a little ahead of itself here and looks back on itself there” (1983:248). Also significant, as this study points out, is that K’iche’ illness narratives tend to be distinctly polyphonic, co-composed of multiple voices and pluralistic experiences (see Burns 1980), while the narratives that Labov describes tend to be largely monologic speech events.

10. In a foundational article on conversation analysis, Harvey Sacks, Emanuel Schegloff, and Gail Jefferson identify and describe some of the fundamental interactional units or components of conversation. Among these components are the “turns of talk”—in a conversation, an interactant’s utterance that either precedes or follows (in a turn) another interactant’s utterance is a “turn of talk.” Participants’ communicative contributions to conversation are thus understood as being constituted of turns, and a series of orderly turns make up what are called “sequences.” Similarly, “adjacency pairs” are two utterances (that are next to one another) produced by different interactants. The second utterance (the second part of the pair) is directly linked to the first utterance (the first part of the pair) in that the second is required, expected, or otherwise anticipated by the first (e.g., two speakers’ exchange of a greeting for a greeting).

11. For an example of an alternative to individual patient as teller of her/his illness narrative, see Basil 1983.

12. Though Moerman is referring specifically to overlaps, his comment aptly describes the polyphonic participatory structure observable in the composition of Maya illness narratives.

13. While the term “talking as a team” (Moerman 1988) does describe some aspects of what is meant here by a polyphonic narrative composition, the former invokes notions of “teamwork” in sports that cannot easily be cross-culturally ascribed to K’iche’ communicative practices.
14. These are curative encounters with K’iche’-speaking healers and Maya wellness seekers.

15. Conversation analysis has revealed a patterned organization of overlaps that demonstrates how participants in conversation orient their communicative contributions toward what are called “turn-constructional” and “speaker-selection principles” (Sacks, et al. 1974). Though conversation analysis is primarily focused on the structure of “conversation” and not “interview,” its observations offer indispensable insights into the study of communicative interaction in general.

CHAPTER 4

1. For a strikingly contrastive ethnographic analysis of silence in illness and healing, see Basil 1983.

2. George Mentore’s work (2005) on silence among the Wai Wai of southern Guyana speaks directly to taken-for-granted Western notions of “presence”-as-being through a lucid explication of silence- and absence-as-being.

3. The other half of communicative interaction is speaking; interactions are thus co-composed of speaking and making silence, foreground and background.

4. By “Gricean,” I am referring to the work of H. P. Grice, particularly, the 1967 lecture “Logic and Conversation,” where he outlines the “cooperative principle” of conversation, which involves four maxims: quantity, quality, relation, and manner. Unlike the Gricean “cooperative principle,” the discourse roles of “communicative silence” reflect not so much maxims as they do the sociolinguistic expectations that members of culturally situated speech communities have regarding the significance of silence in communicative interactions.

5. Note in figure 6, bar 7 is included not to demonstrate silence but rather to show the continuous utterance of the physician that begins in bar 7 and is completed in bar 8.

6. By suggesting that the contributions of “communicative silences” by interactants have mutually intelligible interactional significance, I am asserting that the making and movement of silence in an interaction is a part of the participatory structure of communicative interaction and that, like speaking, it is neither random nor arbitrary.

7. The specific type of transcript method used to demonstrate this point is called “transcription notation,” a technique developed by Gail Jefferson and elaborated by others (see, e.g., Atkinson and Heritage 1984b). It utilizes symbols to identify various types of communicative interactions (e.g., brackets for simultaneous utterances and overlapping utterances, equal signs for contiguous utterances, etc.).

8. In the first instance the response is nonverbal (see WS:8\[2\], C1:8\[2\], C2:8\[2\]) and in the second instance verbal (see C2:8).

9. I say “verbally unanswered” because the polyphonic approach asks the
question whether or not an answer’s “communicative silence” following a questioner’s question can fulfill the discourse role of an answer.

10. In discourse analysis the term “latching” is used to refer to contiguous utterance, that is, to a situation in which “there is no interval between adjacent utterances” (Atkinson and Heritage 1984a:x).

CHAPTER 5

1. I use the term “theurgical herbalist” to describe the therapeutic practices of Miriam and Laura because in their use of medicinal herbs in curative affairs, they invoked divine or supernatural agency.

2. This concept of “being born a healer” has been examined in detail in studies conducted among Tz’utujil Maya midwives around Lake Atitlán; see Hurtado 1984; Paul and Paul 1975.

3. The group that I refer to here includes both older Nima’ townspeople who reported themselves to be monolingual and younger residents who reported themselves to be bilingual.

4. Miriam had no familial relations (kin or affines) in Nima’, and her Momostenecan last name, Sija, also identified her as a non-Nima’ native, and she wore her hair long and flowing, in the style of women from Momostenango, distinguishing her from the women of Nima’, who wore their hair up, wrapped in a xaq’ap (belt). She also used an uq’ with designs distinctive to Momostenango and generally wore it with a Western-style blouse rather than with a Maya po’t. Miriam also spoke a Momostecan dialect of K’iche’. In an extensive dialect atlas of the K’iche’-speaking region of Guatemala, Telma Angelina Par Sapón and María Beatriz Can Pixabaj (2000) show distributions of variations in phonological, morphological, lexical, and syntactic structures that exist across the K’iche’ speech community and distinguish the dialect of each village or region from the next. Many of the characteristic phonological and morphological patterns that distinguish Miriam’s Momostecan K’iche’ from Nima’ K’iche’ are documented and described in this volume. For example, the word ware (tooth), is pronounced [were] in Nima’, whereas in Momostenango it is pronounced [ware]. Also, I observed that the written form “Jas uwach?” (“What is the essence?”) is contracted to “Su?” by Momostecan speakers of K’iche’ but pronounced “Qas uwach?” in Nima’.

5. Furthermore, the ethical guidelines aimed at respecting and not disrupting the healer-wellness seeker and doctor-patient relationship governed and at times restricted my verbal participation in such encounters. Therefore, my interactions with healers and wellness seekers and doctors and patients most frequently occurred before and after their therapeutic and biomedical consultations.

6. It bears mention here that the logistics of recording curative encounters varied with the context and followed the unfolding ethnographic scene surrounding the interaction. For example, at the centro de salud, specifically, patients wait together in the hall before receiving a consultation, and that practice allowed me to seek consent to record the consultation.
prior to patients having any contact with the physician. This, however, was not typically the case at the dispensario, where wellness seekers were frequently able to see the healer moments after their arrival, which meant that permission to record often had to be obtained from wellness seekers after their initial contact with the healer. An exception was when wellness seekers had told me before they arrived at the dispensario that they wanted their consultations recorded. The consultation described in this chapter is an example of the former and as such, recording began after the wellness seeker’s initial contact with the healer.

7. It is interesting to note that while the dispensario made use of long benches outside of the consultation area, within the consultation room individual wooden chairs were used. This is significant because the dispensario is a scene of Maya therapeutic healing, and so one would expect a practice that was consistent with Nima’ residents’ use of space in other cultural contexts. Recall that even the centro de salud used benches rather than chairs as an adaptive strategy during the consultation examined in chapter 3.

8. A similar linguistic observation made among the Tzeltal Maya of Tenejapa in Chiapas, Mexico, reveals that in illness episodes, it is the family and not the wellness seekers themselves who make the request for a consultation (see Metzger and Williams 1963).

9. Though Nima’ residents also pause before entering domestic (not specifically sacred) spaces, the ritualistic pauses at the entrances to explicitly scared sites are (as described in the first part of chapter 4) qualitatively different.

10. Though not discussed here, a number of physio-spiritual conditions commonly referred to as “nerves” or “nervios” have been described as ethnomedical syndromes by researchers from various disciplinary approaches (see Rubel et al. 1991; Jenkins 1981; Jenkins and Valiente 1994).

11. I am referring here to a question that elicits a response that addresses two separate issues (or subjects) raised within the single question. Questions containing two parts can be understood as structurally operating as two questions.

CHAPTER 6

1. “Pulsing” here refers to a Maya spiritual/therapeutic technique used by healers and shamans in southern Mexico and Guatemala to discern a wellness seeker’s specific affliction(s) during a curative consultation (see also B. Tedlock 1992:132–50; V. Turner 1975).

2. Note that in the Tzeltal curative interaction, Metzger and Williams (1963) make mention of the curer’s conversation with the attending family, which is supportive of the polyphonic quality used in this investigation to describe Maya curative interactions.

3. I say “facilitate” because in Nima’, the Maya ajkunab’, ajq’ijab’, and ch’obonelab’ all maintained that they themselves do not heal but rather that divine and/or supernatural forces do the healing.
4. Similarly, Brigitte Jordan’s work on midwifery in the Yucatan shows that during consultations the Maya midwives obtained women’s reproductive histories and information about their family relations and attitudes not by direct questioning but rather in an informal way through their presence in women’s homes (1993:25).

5. Making a similar observation about how narratives were told among the Klikitat Sahaptin of the American Northwest Coast, Melville Jacobs calls these interactive corrections and interruptions the participants’ “identification” with the narrator (1959:268).

CHAPTER 7

1. Coleridge’s concept of a “willing suspension of disbelief” describes “a state of receptivity and credulity desirable in a reader or member of an audience” (Cuddon 1991:1044). Here, it is used to refer to that uncanny experience that emerges from this heightened level of receptivity and credulity whereby the actions of cultural actors that unfold before and within the observers have the effect of transforming those cultural actors (however far removed) into interactants. In such cases, it is not uncommon to find spontaneous utterances from observers being directed toward these apparent interactants.

2. In Guatemala the word “pajas” is widely considered vulgar Spanish slang for “lies.” It varies significantly in its sociolinguistic use from the standard Spanish word for “lies,” “mentiras.”

3. As noted in chapter 4, Maya wellness seekers are rarely unaccompanied in biomedical or therapeutic consultation, but when they are, they are usually unmarried adolescent males.

4. It was not uncommon in Nima’ to hear of families and companions of Maya wellness seekers who would go to hospitals in the city to “rescue” their loved ones before death, bringing them home to be treated by local healers.

5. In this context the Spanish word “curandero” is used negatively and is translated in the text as “quack healer” to convey that sentiment.

6. This point is particularly interesting when one considers that in Guatemala much pharmaceutical medicine is available over the counter without prescription.

7. While changing a child’s name is not uncommon, giving a child the name of someone who is living concurrently with the child is. In Nima’, names frequently came from deceased grandparents and in some cases from epic cultural figures immortalized in the Pop Wuj, the Maya book of counsel.

8. During field research that I conducted in 1994 among the Tzeltal and Tzotzil Maya of Chiapas, Mexico, I noted a similar belief with regard to vaccinations and injections in general. They expressed concern that the hole the needle left in the skin could allow the soul to escape and thereby produce the syndrome known as soul loss.
9. The second portion of health care announcement (in K’iche’) is not provided as an appendix because significant portions of it were unclear, rendering the transcript fragmented.


11. By “Ministry of Public Health,” Hurtado and Sáenz de Tejada mean types of health care agencies that fall under the umbrella of Ministry of Public Health. In Guatemala they are as follows: health posts (with no beds), health centers (which may have some beds but are predominantly maternity care and laboratory facilities), and hospitals (which have beds and a range of facilities); (see Hurtado and Sáenz de Tejada 2001).

12. In “recognizing” Maya midwives and officially “incorporating” them into government health services, WHO strongly urged midwives to promote birth control or “planned parenthood” (see Hurtado and Sáenz de Tejada 2001).
GLOSSARY

achi’l/achi’lab ................ companion/companions
ajkun/ajkunab’ .............. healer/ healers
ajpab’aqab’ .................. bonesetters
aq’ij/ajq’ijab’ .............. day priest/day priests
centro de salud ............. health center
chak .......................... ritual therapeutic work
ch’ob’onelab’ ................ seers/diviners
dispensario ................... dispensary
itzb’al ........................ instruments of evil
iyom/iyomab’ ................ midwife/midwives
k’ayib’al ..................... market
k’olik .......................... there/present
k’o taj .......................... not there/absent
mija .......................... my daughter/child
mijo ........................... my son/child
po’t ........................... handwoven blouse
q’aq ........................... fire/fever
rachi’l ........................ companion
semana nacional
de salud ....................... national health week
tz’ij ........................... word/truth
tzut ........................... carrying blanket
uq’ ............................ woven skirt
uwach uq’ij .................. essence of one’s day/life
wa’ ............................. food
xaq’ap ........................ woven belt-like headdress


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The delivery of health care can present a minefield of communication problems, particularly in cross-cultural settings where patients and health practitioners come from dissimilar cultures and speak different languages. Responding to the need for in-depth ethnographic studies in cultural and communicative competence, this anthropological account of Maya language use in health care in highland Guatemala explores some of the cultural and linguistic factors that can complicate communication in the practice of medicine. Bringing together the analytical tools of linguistic and medical anthropology, T. S. Harvey offers a rare comparative glimpse into Maya intracultural therapeutic (Maya healer/Maya wellness-seeker) and cross-cultural biomedical (Ladino practitioner/Maya patient) interactions.

In Maya medical encounters, the number of participants, the plurality of their voices, and the cooperative linguistic strategies that they employ to compose illness narratives challenge conventional analytical techniques and call into question some basic assumptions about doctor-patient interactions. Harvey’s innovative approach, combining the “ethnography of polyphony” and its complimentary technique, the “polyphonic score,” reveals the complex interplay of speaking and silence during medical encounters, sociolinguistic patterns that help us avoid clinical complications connected to medical miscommunication.