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## **The Weight of the Self:**

Care and Compassion in Guatemalan Dietary Choices

*The Public Health Nutrition (PHN) community categorizes dietary-related chronic illnesses as “noncommunicable,” fixing these afflictions within individual bodies where they are best managed by individual choices. Yet within clinical encounters in Guatemala, nutritionists and patients treat eating and dieting as relational, transmissible practices. Patients actively seek nutritionists’ care, asserting their self-care attempts have failed and they need support from others; nutritionists meanwhile develop treatment plans that situate “personal choice” as lying outside the control of a solitary individual. This article moves between international policy–pedagogy and patient–nutritionist interactions to examine forms of personhood, responsibility, and rationalities of choice present in body weight–management practices in Guatemala. Although nutrition discourses might appear to exemplify how institutional (bio)power manifests through internalized self-monitoring and preoccupation for one’s own self, I argue that within the lived experiences of “nutrition-in-action,” the self–body of the patient becomes broadly conceived to include the nutritionist, the family, and the broader community.*

[care, intersubjectivity, dietary practice, Guatemala]

Marta had been waiting with her daughter and sister on the cold, broken benches of the public hospital for five hours by the time her file reached the top of the stack. I opened the door to a crowd of quiet people and called her name. The three women entered the small room lit by a flickering overhead light, and Sara and Carla— the nutritionists running the clinic that day— greeted them each with a hug. The conversation began casually while Carla helped Marta remove the heaviest parts of her *traje* (indigenous clothing), and then measured her weight and height: How many children do you have? Do you work at home? Who does the cooking? It is so great you have your daughters to help you. While Sara calculated the Body Mass Index (BMI) with her small plastic calculator, Marta joined her sister and daughter at the desk. “So, tell me what you are experiencing. How can we help you?” asked Sara. Marta responded: “I hurt, I have new pains in my body. Ma’am, I am afraid.” Her sister and daughter nodded alongside her. “That’s why we are here for you. We are here to help, and fortunately there are things we can do,” replied Sara. As the next hour passed, they discussed Marta’s situation: a fall from a bus that left her unable to walk without pain in her hip, the weight gain that had started with birth control and accelerated with menopause. Holidays were approaching, her son was unemployed, and she was anxious about managing her family’s expectations with her husband’s small income. They spoke about foods: those the family liked and those they did not, what they typically ate at each meal, and where Marta bought her groceries. At each juncture, Sara added some advice: ways that Marta might reduce the oil she used, how she could batter vegetables in egg whites but discard the yolks, that low-fat milk was less expensive in powder than in liquid. She also echoed an idea I heard during every consultation: “This process is slow. You have had a lifetime to develop a certain set of habits and it will take time to change them. Be patient. We will make small and gradual changes; it might start off hard, but it will get easier. We are here for you, we will help you.” By the end of the consultation, Marta seemed more at ease. “Thank you. Thank you. I need your help so much,” she said. They scheduled a return visit for two weeks later, and then the women embraced again, giving each other a kiss on the right cheek, as is customary between friends in Guatemala. When the door closed, Sara sighed loudly: “I am worried,” she said, as if to herself, looking at the papers in Marta’s file. “There are a lot of changes we have to

make, but I think we can get better (podemos mejorarnos).”<sup>1</sup>

## Relationships of Power; Relationships of Care

I arrived at my field site in the Guatemalan highlands in January 2008 prepared to think about relationships of power.<sup>2</sup> Medical anthropology has contributed important insights into techniques by which bodies and selves have been colonized— commercialized and commodified through medical practices. For my research on Public Health Nutrition (PHN) and weight-loss programs in Guatemala, I anticipated the hierarchies, inequalities, and power relations at play within Guatemalan nutritional discourse. Yet, through my research I came to see a focus on power as insufficient for understanding the varied interactions of clinical exchange. Power is important, but a different framework is also needed: one that considers medical practices that operate amid constraints of hierarchy and control, employing compassion, concern, and relationality. This article is part of an effort to think through a different logic of clinical practice: “a logic of care” (Mol 2008).

Over three decades ago, Foucault outlined two conjoined disciplinary poles of “power over life” (1978:140; also called “biopower”). The first pole— anatomo- politics—operates through a focus on individuality and pathological anatomy creating subjectivities imagined as self-contained. The second pole—biopolitics— operates through technologies of normalization, which facilitate the classification and control of “anomalies” in the social body. In my fieldwork, I encountered several ways in which international public health institutions clearly framed nutrition through a logic that mapped onto each of these poles. In their conferences and publications, PHN described metabolic illnesses as individualized (i.e., *non-transmissible*) and not communicable, fixing the notion of dietary health within individual bodies, and ultimately imploring individuals to “increase one’s nutritional awareness” (see also Ferzacca 2000; Lester 2007; Montoya 2007; Rock 2003; Waitzkin 1991). PHN also had a “lifestyle” focus and commonly emphasized the importance of body-weight statistics for treatment of dietary-related chronic illness. Through BMI, one’s body (and self) becomes interpolated through social demographics without regard for particular dietary or exercise patterns. Hacking describes BMI as a classic example of “making up people”—referring to the ways in which the standards and deviations of diagnostic categories translate persons into bodies that are calculable and

controllable (1986, 2007). Numerous scholars have pointed out that while disciplines of calculation such as BMI declare their objectivity, they impose new imperatives that continuously produce identities conforming to the will of the body politic (Asad 1994; Briggs 2005; Maynard 2006; Scheper-Hughes and Lock 1987).

And yet, when moving away from the domain of the conferences and publications, into the realm of nutrition that takes place in the interpersonal exchanges of clinical practice, I began to see something other than power affecting nutritional care. Nutritionists in the clinic where I conducted fieldwork largely disregarded the statistics-based lifestyle charts emphasized by nutritional protocol, instead directing their attention toward specific context-dependent desires and needs. Additionally, treatment did not focus on an individual “self.” Instead, the employment of the first person plural tense (i.e., “us” and “we”) during clinical exchanges, the use of dietary recommendations that downplayed personal choice, and emotional connections that formed between patients and nutritionists suggested that treatment was a highly *relational* process. Dutch ethnographer and philosopher Annemarie Mol has written that social scientists’ focus on medical power and the problematic ideal of health, while valuable, has left us without a language for describing practices of “good care” (2008:89–90). Similarly, I found that my understanding of social inequality in medicine did not help me to account for all of the caregiving practices that took place in the clinic.

Although something akin to care has been central to many anthropological analyses, this care has been viewed as institutionalized, selfishly motivated, and potentially dangerous. Scholars have clearly pointed to the intimacies and affections that mobilize forms of governance, drawing attention to how colonial and postcolonial dominations migrate outward toward people’s homes, kitchens, and bodies through discourses of pedagogy, parenting, and servitude (Mitchell 1988; Sommer 1991; Stoler 2002). Foucault writes that the medical establishment, although endowed with the responsibility of protecting a state’s populace, nonetheless “exercises an uncontrolled power over people’s bodies, their health, and their life and death” (1982:780). He further describes power as “a total structure of actions brought to bear upon possible actions; it incites, it induces, it seduces, it makes easier or more difficult; in the extreme it constrains or forbids absolutely; it is nevertheless

always a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of action. A set of actions upon other actions” (1982:789). In other words, he reinscribes action—all action, including care—as a deployment of power.

Since the 1970s, the concepts of ideology, hegemony, dominance, subordination, resistance, and, more recently, biopower have become a mainstay within ethno-graphic inquiry (Ortner 1984). Anthropologists, myself included, are poised to see medical practices in terms of hierarchy—to think about when and how another (the “Other”) is subordinated, excluded, made inferior. Much recent analysis of public health proceeds from concern about state power (cf. Briggs 2003; Osborne 1997). Yet my research took place in the neoliberal landscape of Guatemala, where numerous political parties fought for control over a government often described as *castrado* (castrated), and where people were trying to build lives and communities out of the scattered wreckage of ongoing decentralization. The Central American Free Trade Agreement, largely promoted by multinational corporations, took effect in 2006, resulting in increased unemployment of countryside farmers and the proliferation of processed foods and multinational grocery stores (Asfaw 2008; Hawkes and Thow 2008; Leatherman and Goodman 2005). Escalating rates of metabolic illness overwhelmed understaffed and underfunded government-funded health centers. Most people I spoke with about the president, Álvaro Colom, described him as a *débil* (weak) man. “The drug cartels and gangs, the army generals, the economic elite, and the World Bank control Guatemala. Our government does nothing,” said one of my homestay fathers, summarizing a pervasive disdain for the lack of state investment in Guatemala’s social infrastructures. For the people I got to know, clinical care was not a threat, but a *f fuente de esperanza*—a source of hope. Hirokazu Miyazaki connects hope to an abeyance of agency (2004). This is fitting to my analysis here, although I suggest that the abeyance of agency in clinical interactions comes not from an overall lessening of agency but from the creation of an intersubjective space in which agency becomes distributed and shared.

In this article, I draw from Bruno Latour’s emphasis on the importance of studying science “in the making” (1987:14), to argue that nutrition-in-action is a practice enacted in human relationships that is incompletely described through analyses developed around concern for power. Power is part of

nutrition, but the idea that forms of control—be they centralized or diffuse—pervaded all actions of the people with whom I lived and worked seemed incongruous with many of the health care engagements I saw. Instead, I point to the importance of care, by which I mean an affect of tenderness, empathy, compassion, and respect. I suggest that care happens in the spaces of personal relationships, in linkages between formerly separated bodies and selves, in the intimacies that form between one and another. It defies power's calculative demands of more than, or less than; it cannot be fixed within regulatory poles. It is not *against* power (it is not resistance); it is simply a different way of being in the world. To borrow from Mol, it follows its own logic (2008).

## Methods and Procedures

The purpose of the project was to gain access into the emotional qualities of nutrition-in-action through repetitive daily participation in clinical life. I conducted 16 months of fieldwork in Guatemala's third largest public hospital, which was located in the western highland state of Quetzaltenango, including an eight-month period of intensive study. Between January and June of 2008, I made weekly visits to the hospital, described in the next section, where I learned about the hospital's nutrition services through interviews with nutritionists and while observing their typical daily activities. On Tuesdays and Thursdays the nutritionists ran a clinic offering outpatient nutrition services, and between July 2008 and April 2009, I attended these consultations from the time they began in the morning until the last patient had left—usually in the early afternoon. In total, I observed approximately 600 clinical consultations. I recorded roughly 400 of these consultations digitally with consent from the nutritionists and patients following my university's protocol for research with human subjects, while simultaneously taking written notes about the clinical encounters. I later transcribed selections of recorded “talk” which contained often-repeated themes about control, responsibility, and treatment (Goffman 1981; Mishler 1984). I also met with 30 return patients at their homes at least once—and often several times—for follow-up interviews and conversations outside the hospital setting (see also Gooldin 2008). I lived with local families during the 16 months of my research. One of these homes I shared with a student in the nutrition program described below, and several of the families made use of

the hospital services during my stay with them. Although this article focuses on the clinical setting, all of these experiences inform my analysis.

I was not a nutritionist, but following anthropology's long-standing tradition of participant-observation ethnography, I spent months sharing their cramped office space, navigating the arduous bureaucracy of the hospital's administration with them, and laughing with them on breaks about life-matters having nothing to do with nutrition. Neither was I a patient. But, I ate meals with patients, spent time in their homes, got to know their families, and listened to their stories about confusion, recovery, and pain. I harbor no pretenses that I felt exactly what the people I worked with felt, but I also know that our interactions provided me with new insight into the intersubjective realms of caregiving practices.<sup>3</sup>

I draw from these experiences to suggest that international and institutional nutrition programs that formulate chronic illness treatment in both individualizing and biopolitically regulating ways do not encompass all relations of care that form through clinical encounters. This is not simply an argument about the contradictions between protocol and praxis—although it is notable that ethnographic engagement illuminates an aspect of treatment obscured by the textual analyses of official documents and agendas. Instead, I show how people participate in care of the *intersubjective* self. Whereas Foucault sought to study “the way a human being turns himself into a subject” (1982:778), I focus instead on the relational spaces of nutritional health engagements. I further suggest that within intersubjective practices of care, difference is not necessarily constrained within hierarchy. An other is not always the postcolonial “Other.” Metaphorically: we do not see the arm as more powerful than the leg, but as parts of the same conjoined body.

With this in mind, I turn to descriptions of the hospital with the following question: What might we find when we use “care” and not “power” as the lens for our inquiry into clinical relations? I begin with a discussion of the hospital and outpatient clinic where I conducted my research, outlining key concerns raised by nutritionists and patients. I then turn to examine the dynamics of clinical exchanges to highlight techniques of caregiving that emerged in treatment practice. In the subsequent discussion, I revisit my argument that a focus on the role of power in medical encounters limits researchers' abilities to see the importance of emotional and affective

relationships present in nutritional treatment. I conclude by suggesting that the field of medical anthropology, precisely because of the focused and engaged methods of its research, is well positioned to develop analyses of care that will enrich future studies of clinical practice.

### Study Setting: Nutrition Practices at Hospital Regional San Juan De Dios

Hospital Regional San Juan de Dios is the third largest hospital in Guatemala, located just up the hill from the Burger King, at the edge of Xela's urban sprawl, where wheat fields used to grow.<sup>4</sup> Because Guatemala's two larger hospitals are in the capital, a four- to five-hour drive to the east, many people suffering from illnesses throughout the country's western highlands sought treatment here. Almost all patients were poor, some very poor, and given the large demand for the hospital's services, many people had to spend several days in the hospital's neglected lobbies and unlit hallways before they were seen.

According to the director of nutrition, *Licenciado* (Professor) José Morales, the hospital has responded to minor nutritional concerns since 1998, but the services then were extremely minimal—mostly focused on immediate treatment of life-threatening malnutrition. In 2001, hospital administrators scraped together re- sources to begin to address the nutritional health of patients admitted to the hospital with acute respiratory and gastrointestinal illnesses, and to respond to the needs of some children admitted with severe malnutrition. But in 2004, they ran out of funds for staff, the requisite equipment (bags, bottles, needles), as well as fortification packets and other resources to provide basic sustenance. The nutrition services ended.

“Lic,” as people fondly called him, was an impressive and charismatic man, well known and well liked by doctors throughout Xela's medical community, who often laughingly pointed out to me the irony that a fat man was in charge of Xela's nutrition. His vision for the hospital's nutrition services were ambitious and comprehensive:

We are also the only hospital outside of the capital to offer nutritional services. We have 350 beds—beds all filled with sick patients. We should have at least six full-time nutritionists. This doesn't even include what I'd



really like to see. We should be working with social workers to better serve our patients; we should be conducting studies of our services to ensure they're effective; we should be implementing educational programs that help prevent the diseases of malnutrition. In the last 10 years, the diagnostic incidence of chronic illnesses like diabetes, renal failure, high cholesterol, and high triglycerides has skyrocketed. So many people are coming in overweight or obese. We're doing what we can, but we're in no way prepared for this.

Morales was one of two full-time nutritionists paid by the hospital. It was his idea to bring students from the nutrition program at the Universidad Rafael Landívar— a program he helped to start—into the hospital, where they received hands-on training while also expanding the nutrition services the hospital could provide. Since June of 2007, third- and fourth-year students (nutrition is a five-year degree) have staffed the hospital. The hospital does not pay them for their work, but they receive both university-credit and practical experience working with patients. Landívar administrators told me that nutrition was one of the most rapidly growing areas of study in the university, with each successive class larger than the last (growing from seven to roughly 30 per cohort since the program began in 2003). They thought other schools in the city would soon start developing nutrition programs, although when I did my research the Landívar was still the only one to offer the degree.

Although the Landívar is a private university, many of the nutrition students were from families that struggled economically and had selected nutrition because it was less expensive than medicine. The students came from both indigenous and nonindigenous families, although like most of Xela's youth, everyone spoke Spanish and wore clothing of *estilo oeste* (Western style).<sup>5</sup> The program's mission statement included: "Strengthening in the nutritionist the principles of humanism, ethics, and social concern (*proyección*)." All the nutritionists, when explaining to me their reasons for choosing their field of study, described a desire they had to help others. As with most professional degrees in Guatemala, the students had chosen their career path while still in *diversificado* (high school). Born in the mid- to late 1980s, they had been insulated from the direct terror of genocide and instead were raised in an era of attempted reconciliation, postwar reconstruction, and ongoing ethnic and

economic inequalities. They saw nutrition as a key site where social injustice might be addressed. “So many people in our country are sick with preventable illnesses,” one woman told me. “It is my dream to be able to help. The benefit of nutrition is that it takes just a little knowledge to produce an immense benefit in people’s lives.” Although an emphasis on “increased education” often masks social inequalities (cf. Miewald 1997), the public hospital nutritionists saw their services as providing—as one nutritionist phrased this—“low-tech, and generally low-cost, solutions to devastating health problems.”

The hospital was organized in such a way that the nutrition clinic remained separated from other hospital services. As a result, I had little contact with doctors, so my analysis focuses on the patient–provider exchanges within the nutrition clinic. As is also seen in the profession of nursing (Benner et al. 1996; Gordon et al. 1996), the space of the clinic was deeply gendered. Although many of the hospital’s doctors were men, almost all of the nutritionists were women. With the exception of Lic. Morales (who organized the nutrition program but was never present during consultations), just two men studied nutrition while I was there. Most people seeking out the services were also women, generally between the ages of 40 and 55 who listed their occupation as *ama de casa* (housewife). Guatemalan public hospital services are free with the exception of labwork, although patients generally endure long waits for treatment, a reason why many people I spoke with—especially men, who were more likely than women to be employed in wage labor—said they were obligated to seek treatment in private clinics or forego it altogether. It was common for patients to arrive from several hours away, only to spend the day waiting for a single evaluation. It was also common for the extended family to arrive in tow; daughters, nieces, sisters, and cousins regularly accompanied patients at the clinic. When patients would arrive alone, the nutritionists would always ask where their family was, encouraging them to bring support for the next visit. *You’ll need someone to help you to remember all of this, to help you cook in this new way, to encourage these changes*—they would say. Family members never waited in the lobby during a consultation; they were part of the care.

Between roughly eight and 15 patients arrived at the nutrition clinic each Tues- day and Thursday of my fieldwork, coming through referrals from

doctors in other units of the hospital.<sup>6</sup> By the time we saw them, patients had already received their medical diagnoses, the most common of which were diabetes, hypertension, elevated triglycerides, uric acid, and gastritis. Nearly all patients also had the con- current diagnosis of *sobrepeso* (overweight), considered by medical professionals in Guatemala as a disease unto itself. According to administrative protocol, the primary duty of the nutritionist was to provide a dietary evaluation that would enable weight loss by helping patients to eliminate *cosas malas* (bad things)—this usually referred to fats and sugars—from their diets.

On these two mornings a week, the particular nutritionists who had been selected for the three-week rotation of the *consulta externa* (outpatient consultation) would leave their morning class early, around 9:00, to collect the day's list of patients from the staff at the front desk. The patients—even those traveling by bus from towns several hours away—arrived when the main doors opened at 7:00 to ensure their names were added to the day's list (handled by administrators, not nutritionists). Clinic rooms were barren, with a simple metal desk, three chairs, an examination table, a scale, and an empty wastebasket (which I turned over each morning to use as my chair). This was not Foucault's carefully monitored panoptic clinic, organized to “allow a better observation of patients” (1973, 1977:69). Instead, patient surveillance was anything but meticulously monitored; the lack of systemic oversight was a daily obstacle, and hospital administrators often lost or misplaced the charts and records, leaving no history of a patient's treatment. (Given the nutritionists' rotations, I was the only consistent presence at the clinic and my field notes often served as the sole record of a returning patient's previous visits.) All patients carried with them an official hospital appointment card, authorizing their entry to the hospital. But, when they first visited the nutrition clinic they often did not know what illnesses they were being treated for, what lab work had been done on them, which doctors they had previously seen, or the names of the medications they were taking. This information, which theoretically could be found in their charts, was often absent: missing or never entered.

If the scale in the room worked (many did not) the nutritionists measured the patient's weight and height and then calculated his or her BMI. If not the patient and nutritionists would go knocking on hospital doors in pursuit of a

functional scale. Then, over the next hour, while sitting across the desk from the patient—and often several members of the extended family—the nutritionists would inquire into typical meal patterns and preferences. As seen in the following characteristic advice, they guided patients about which foods to eat and which to avoid, encouraging and admonishing certain behaviors: “Don’t eat much sugar. Don’t eat much fat. Drink water. Eat fruit. Exercise, half an hour per day. Walk. Walk, because this will help you tremendously.” While giving these recommendations nutritionists would repeatedly ask if patients understood the guidelines, if the advice sounded reasonable, if they would have trouble following through with different dietary recommendations, and if they could afford the suggested foods. The nutritionists were conscientious that, in the words of one nutritionist, “to advise useful changes in eating habits, we need to know the patient well.” In the time they spent with the patient, nutritionists asked numerous questions about their family structure: who lived in the family, who cooked and shopped for the family, and what kind of financial possibilities and constraints the family might face. Patients, in turn, shared with the nutritionists their physical pains, domestic concerns, and social anxieties. We heard a lot about husbands and children. And the nutritionists did not just listen, but also shared some of their own experiences at times when they thought these were relevant.

Later, after the day’s services ended, the nutritionists would design a personalized diet-plan for each patient, taking into account likes and dislikes and incorporating dietary recommendations (no salt, no fat, nothing acidic, etc.) that accompanied particular illnesses. This customized plan—referred to as both the *menu* (menu) and *tratamiento* (treatment)—had seven vertical columns for days of the week, and five horizontal columns for meals and snacks, making a grid of the week’s suggested food and beverage quantities. According to clinic protocol (which continually crumbled in the face of obstacles of everyday life), the following week patients were to return to the hospital, meeting briefly with the nutritionists who would then give them their diet and address their confusions or doubts. The nutritionists would encourage a follow-up appointment a few weeks later in order to monitor changes in weight and blood work (brought from lab results performed separately), and adjust dietary recommendations.

There are important reasons why the *dieta* (diet) prescribed by the nutritionists might be seen as a technology of power. The recommended daily allowances for nutrients and calories that nutritionists used to calculate the menus came from tests and examinations conducted with U.S. populations. They then adjusted these “universal” guidelines to their individual patients’ needs, ensuring that the foods totaled the desired per-day calorie count (1,800, 2,000, 2,500) and contained the correct quantity of vitamins and minerals. The focus on permitted and prohibited foods responded to PHN demands for consumer education, enforcing an ethic of personal responsibility by encouraging smarter choices. In this respect, the diet encouraged lifestyle changes that would optimize one’s (self) control of food and consumption patterns. Take for example, a typical lunch (to be prepared without oil or salt): 1 cup of herb broth; 1 cup of boiled vegetables; <sup>1</sup> cup of pasta; 3 tortillas or 2 tamales; 1 cup of orange juice. The individualized preparation and serving sizes were puzzling to the woman prescribed this meal. After her first nutrition consultation, when I visited her home—a ramshackle lean-to at the edge of the city, far from the nearest road on a winding path that wove past small plots of farmland and emaciated cows—she showed me that she only had one cooking pot, one pan, and a two-burner stove. *It’s simply not possible to cook for myself, separating my food from the food for the rest of my family*, she said matter-of-factly. It was clear that this diet, made following a single visit to the clinic, was too impersonal to be helpful, isolating her from the social system in which her dieting practices took form.

Yet while there were ways in which the diet might differentiate the individual from the community—creating and then providing techniques of management for the newly created self—in many situations, the nutritionists and patients both saw the diet as a means of alleviating what one patient called *el problema de elegir* (the problem of choice). Numerous scholars have described how a focus on “correct” and “healthy” dietary choices overlooks factors such as import/export tariffs, food subsidies, and the availability of foods that influence dietary decisions (Ferreira and Lang 2006; Hunt and Arar 2001). The nutritionists themselves recognized that much about what and how their patients ate remained tied to conditions beyond personal compliance, including workday schedules, the cost of food, and the gendered and generational obligations of eating or abstaining. By helping

patients to plan their meals—specifying the quantity and type of foods to be eaten—the nutritionists sought to remove from patients the responsibility of choosing “proper” foods on their own.

Moreover, there was a shared sense among both the nutritionists and patients that the diet was simply a template on which teaching and learning could be set into action. Conversations that began focused on diets would soon transition into other concerns about food, eating and life in general; it was through the diet that they began to engage in the merging of agency surrounding patient choice. When a patient once acknowledged losing the diet she had been given, her nutritionist responded: “It’s okay. This happens. What is important is that you’re here.” Whereas official protocol focused on the details of what to eat and to avoid, in practice the nutritionists and patients framed the details as less important than the overall exchange of interactions between the nutritionists and patients and their families. When patients did spiral into concerns about making proper choices—“Can I eat melon? Should I not eat melon? How much? Do I eat it at 10:00, at 2:00, at 8:00?”—nutritionists would calm them, emphasizing that balance and sustainability were more important than any one specific decision.

### Consulta Externa

Josefina: How am I?

Eloida: Well (*looks up from the calculator*), you’re just a tiny bit overweight.

Josefina: I am? How much should I weigh?

Eloida: Well, at least—we at least have to—just a minute (*calculates*). Well, we must lose at least 20 small pounds. But it’s not going to be, for example, that I tell you this now and next week you come having lost the weight. No, It’s going to be bit by bit, bit by bit. You’ll see, we’ll do it bit by bit. This is why we are here for you—since sometimes one cannot lose weight on their own, right? I know how it sometimes goes: you say to yourself, I’m not going to be bad, I’m not going to eat. I’m going to put a zipper on my lips and not eat. But this doesn’t work, does it? It doesn’t work to lose weight all at once. So what we’re going to do here is to try to eat healthy and try to improve your weight in a manageable way so that next time you’re here you feel better and you can say, “look, I’ve lost a little bit.” A little is something,

right? Great, so let's begin. Do you drink low-fat milk, or what kind of milk do you drink?"

There is much to unpack in the above dialogue, but I want to begin by drawing attention to the nutritionist's use of the first person plural voice—the “we” (in Spanish: *nosotros*)—to encourage changes in their patients' diets. The quality of care provided by different nutritionists was by no means uniform; some were more patient, attentive, and devoted to their patients than others. Yet this pattern of first-person identification—and the consequent blending of patient–provider subjectivities as nutritionists adopted the voice of the patient—was present across the many months of nutritional exchanges I observed. “*We* must lose at least 20 small pounds.” “*We'll* do it bit by bit.” “What *we're* going to do here is to try to eat healthy.” This was not a patronizing “we”; the nutritionists were typically a generation younger than their patients and conscientious of the respect warranted by this difference in age. When I asked the nutritionists if the first person plural identification was something they had been trained to do, they responded no—they were not even aware they were speaking in this manner; it simply emerged through relational practices of caregiving.

It was clear to me that nutritionists saw themselves participating in their patients' illnesses and understood that to be integral to their recovery. They thought about their patients at night; they discussed patient concerns with each other during breaks from classes; they worried when patients missed their appointments. In all of my time at the hospital, the nutrition supervisors or hospital administrators never set foot in the clinic rooms to oversee patient treatment. The nutritionists were neither paid nor evaluated on their performance, so there was no tangible repercussion to treating patients quickly, or poorly. And yet they stayed, often through the lunch hour, sometimes cutting into their afternoon classes. They listened, they advised and, to some degree—albeit, perhaps small in the face of the health challenges the patients faced—they carried their patients' lives and stories with them.

The patients, in turn, expressed a strong appreciation for the nutritionists. When I visited patients at their homes, they often underscored their feeling of hopelessness about their illnesses. They described their pains—swollen, aching limbs, racing hearts, breath so shallow they felt as if they were

suffocating—alongside a debilitating confusion about which foods were healthy and which were not. They often bemoaned contradictory advice they received from various sources (radio, television, friends, kin, and doctors): avoid avocados, they are high in fat; avoid carrots, they are high in sugar; avoid beans, they are highly acidic; avoid potatoes, they have too many simple carbohydrates. Much of this advice existed alongside other basic messages: avocados, carrots, beans, and potatoes are healthy. Whereas many patients were confident in their culinary knowledge, the food environment around them had shifted rapidly. As a result, both metabolic illnesses and their treatment strategies were largely unfamiliar. They saw their nutritionists as providing an expertise about these illnesses that they lacked; their nutritionists, they told me many times, also gave them encouragement, help, and hope.

While visiting with patients outside the hospital, I looked for and anticipated critiques of the nutrition clinic: the long waits, the lost charts, the inclusion of unknown or prohibitively expensive foods in the diets. Numerous return patients did not lose weight over the course of their visits, and I expected that a frustration about this would affect their affinity for their nutritionists. And patients did indeed get frustrated. Yet repeatedly, they drew distinctions between their feelings about the hospital's structural inadequacies and their relationships with their nutritionists; while they lamented the weaknesses in Guatemala's health care system, they were unfailingly complimentary about the nutritionists with whom they worked. Diana's comments about her nutritionist, Marleni, are representative:

“I really needed support with this. I needed someone to be there for me. I was so relieved when I learned about the counseling for nutrition. I had been trying to do this on my own. But I didn't know where to start. My family wants me to get better, but they don't understand my situation. I'm so glad to have Marleni's help.”

Diana had felt her health deteriorate, and she spoke of a deep stress she experienced surrounding her role as family caretaker. Her children were busy in school; her husband was busy at work and with his friends. She emphasized her love for her family repeatedly while we spoke, but she said she also often felt taken for granted. She explained that when she brought her family with her to the hospital, Marleni was able to both legitimize her



illness—which was not immediately visible—and voice a need for changing some of their household patterns. On numerous occasions patients expressed the idea that nutritionists authorized, and by doing so enabled, dietary transformations—transformations they were not able to make on their own. In Diana’s words: “They were not listening to me, but they listened to her.”

I was surprised by the eagerness with which patients turned their well-being over to their nutritionists. Patient after patient spoke of a failure to treat their illnesses by themselves. Over the course of my fieldwork I lived with numerous people suffering from, and managing, weight-related chronic illnesses. They all had creative tricks for treatment. Many stretched out their medications, taking pills only in response to physical symptoms—a tremor in their heart, pulsing blood pressure, incredible thirst, or pain in their limbs. Most manipulated their diets in some way: one woman ate copious amounts of garlic, another woman drank *licuados* made from the Noni fruit (rumored to contain magical health properties) at 3:00 P.M. every day, another microwaved an egg in a plastic cup each morning to avoid the oil of a frying pan. Those who lived with chronic illnesses sweetened their desserts with artificial sugar packets and often drank teas brewed from a range of natural herbs, foregoing the traditional beverage, coffee, because of rumors it was harmful. Many patients swore by these methods, but by the time they arrived to the nutrition clinic their sickness and corresponding exhaustion had facilitated an openness for the nutritionists’ advice. They had pushed up against the limits of the *care of the self* and were now relieved to find themselves in the care of another. Take for example the following conversation between Sara, one of the nutritionists, and her patient Carmen, who enters the conversation with theatrical despair.

Sara: Good morning, Doña Carmen. How are you?

Carmen: Look, what I need is for you to help me. (Raises her arms upwards). Please, let’s skip the formalities: I know it. I need to lose weight.

Sara: Oh good, you’ve got it (laughing).

Carmen: Because, you see, I’ve already done all that I can on my own (*ya puse todo de mi parte*) and just look at me. This is where my own efforts have gotten me. Well, just look! (Waves her arms, then points toward her

stomach).

Sara: Okay, yes.

Carmen: So I want you to do whatever it is you do with yourself, to me, okay. You just tell me what you do, and I'll do it. Tell me what you eat, and I'll eat it. Whatever it is that you do, I'm going to do. I'm in your hands: teach me.

Sara: Oh, this sounds like a good challenge for us.

Carmen: Yes, fortunately I like a challenge. And clearly we're in for one.

In the above discussion, Carmen is uncharacteristically direct and confident in the clarity of her demands; most patients were extremely humble and took circuitous routes to arrive at statements of their needs. Nonetheless, Carmen's desire to comply with her nutritionist's recommendations was common. Numerous patients expressed a desire to be trained, in Bourdieu's terms "inculcated," in the education system of public health nutrition (1977). They actively sought the highly structured social practices that would help them to enact a set of dispositions wherein divisions between intention and habituation, rationality and emotion, or corporeal and mental would dissolve.

I understand the often-repeated desire from patients to mold their bodies in accordance with medical standards of health in two ways. First, I draw from Saba Mahmood's suggestion that expressions of docility and willing subordination do not necessarily imply an abandonment of agency. Mahmood points out that to be instructed in knowledge or skill requires significant malleability and that the work people undertake to achieve this malleability "carries less a sense of passivity and more that of struggle, effort, exertion and achievement" (2001:210). Second, I suggest that agency-within-compliance does not require a single actor. Extensive scholarship on the acquisition of cultural practice has demonstrated how knowledge—including embodied knowledge—becomes legitimated through dialogic systems of practice (Goodwin and Duranti 1992; Jacoby and Ochs 1995; Lave and Wenger 1991). Roughly a century of research into educational practices has situated "culture" and "cognition" as (always-already) constitutive of one another (Morris 1994; Wertsch 1985). As far back as 1934, G. H. Mead, who held that meaning was coconstructed and that action was inherently social, described the "self" as forming from attitudes held by a group; by extension,

“one has to be a member of a community to be a self” (1934:162).

I elaborate this to emphasize that not only does the notion of self form through praxis but also that action—agency, or choice—can itself be shared. “*You tell me what to do.*” “*You teach me.*” Carmen expresses clearly her desire to be trained: “*Whatever it is that you do, I’m going to do. I’m in your hands.*” Carmen does not ask Sara for a personalized diet plan, corresponding to her individualized needs. She instead tells Sara: “*I want you to do whatever it is you do with yourself, to me, okay. You just tell me what you do, and I’ll do it.*” To these requests Sara responds affirmatively, acknowledging this desire with the first person plural objective pronoun “us.” “*This sounds like a good challenge for us.*” They, together, will be the target of the challenge. Carmen reiterates this, confirming the bond: “*We’re in for [a challenge].*”

From my vantage on the other side of the examination room, the distance between Carmen and Sara at first appeared prohibitively wide. Carmen was an elderly housewife from a poor neighborhood in Xela, obese by medical diagnostics; Sara was young, with ambitions to travel, and had a thin frame and no serious health concerns. Yet despite the divides between patients and nutritionists—age, education, ethnicity, clothing, language, or body size—they continuously found similarities from which to develop a connection.

One way patients and nutritionists commonly built rapport was by positioning past behavioral habits as an obstacle to health that they could ally against together. The nutritionists situated many behaviors as existing outside patient control; it was not the patient’s fault that her appetite was uncontrollable because she didn’t yet have the requisite skill set for “correct” or “healthy” dietary management. Their aim was not to undermine patient expertise; the nutritionists held that effective treatment required not just listening to but valuing patients’ existing approaches to eating and exercise (they recognized their professional expertise was itself contingent on patients’ knowledge about their own dietary routines). In other words, nutritionists’ claims of expertise aimed to attenuate the rhetoric of individual responsibility seen in many discussions of choice. By assuming shared responsibility for patients’ food choices, nutritionists hoped they could transform patient’s eating practices in a way that alleviated misplaced and harmful implications of personal blame.

This lessening of patient responsibility—and of the corresponding culpability—is also pronounced in descriptions of *ansiedad*. In Guatemala, *ansiedad* refers to both a general sense of anxiety—an uneasiness or trouble of mind about some uncertain event (OED)—as well as to the cravings of appetite. See the examples from hospital transcriptions below for occurrences of this latter usage:

### *Example 1*

Nutritionist: Well, we're going to have to lose some weight. Patient: Yes Ma'am. But this *ansiedad* that I have. The *ansiedad* for food hits me. It overtakes me, and I feel as though I'm drowning in it. I must eat something." N: Well, the thing is that you need to eat. Not to eat so that you gain weight, but so you can eliminate some of this *ansiedad*. If it gets to be 10:00pm and you haven't eaten, the *ansiedad* will win. You will eat, but more than you want because you will be eating for *ansiedad*."

### *Example 2*

P: [Do I need to eat] a lot, Ma'am, or just a little? It is so hard to eat less. I don't want to die from hunger. N: Don't you worry. We're going to give you—P: It's one thing to be sick. But also to be sick from hunger? I'm sick, but what I am, is sick from hunger Ma'am.

N: You have a lot of hunger? P: Oh yes! N: Or is it *ansiedad*? P: Oh it's both. I have hunger. I also have *ansiedad*. N: Yes, this *ansiedad* is a problem since you must lose weight. But we can help you treat it.

### *Example 3*

P: If I start to feel the temptation from a snack, I eat a piece of papaya or something like this. But not, but not—

N: Perfect! This is exactly what we'd like you to do. This is why we indicate you should eat food five times a day. If you eat breakfast at 7 in the morning, by 10:00 you're going to be hungry. You must eat something then. If you wait much longer to eat, then you will eat everything you put in front of you.

P: Yes, everything.

N: So what we're trying to do is to help you avoid the *ansiedad*. Right? So

you don't eat whatever is in front of you—so you don't eat too much.

#### *Example 4*

N: So it would be better if—P: But I've already tried this. I've already tried to eat less.N: Yes?P: When I start to eat less, I get this feeling. . . . It's like something else is in charge. I have this urge to—N: Ansiedad, we call this.P: Yes, ansiedad. And I am no longer in control. I don't drink [alcohol], but it's like a thirst.N: Yes, yes. We have [food] recommendations that can help you with this.

The nutritionists saw themselves as integral to patient care, sharing with patients the responsibility of eliminating the behaviors that produced the ansiedad that would deny them control. Counterintuitively, the nutritionists saw one of their primary jobs as ensuring that patients would eat both regularly and enough. In this goal they also elicited help from the patient's family, telling a daughter, for example, to see that her mother eats breakfast, does not let hours pass before eating again, and does not simply snack on bread and coffee for dinner. As seen in Example 2, the nutritionists differentiated ansiedad from hunger. Hunger was an unavoidable—even necessary—sensation, located at the juncture between body and mind that surfaced as a response to the body's need for sustenance. Ansiedad was also a physical and mental response to perceived need, produced by the act of restriction. But anxiety, unlike hunger, was a detrimental sensation. It was seen as a trick of the bodymind, causing desire for more than was healthy for the body.

According to the nutritionists, ansiedad, was capable of trapping the patient in unintentionally self-destructive cycles. So-called rules of common sense (“eat less”) became impossible to follow and so-called smart choices (“choose healthy foods”) became impossible to make. The sense that an “agent” outside the patient would bring about illness aligns with a communicable model of disease; in this case, however, the agent is at once outside the patient, and the patient herself.

Ansiedad, as described by patients who spoke of feeling controlled by their appetites, was an experience in which a unified, rationally acting self disappeared. Competing desires (to eat, to abstain from eating) collided,

leaving sick, exhausted, and depleted patients in their wake. Both patients and nutritionists viewed the drives and desires of the body and the mind as often deceptive, containing an agency that superseded a patient's well-being. The nutrition consult presented an opportunity to intervene in the divisions in the self that patients experienced; the incorporation of the nutritionist into the phenomenological interstices of illness facilitated the slow process of improving well-being, as nutritionist and patient worked together to make changes in behavior.

It is important to emphasize that an ethos of choice was not irrelevant in the discussion of nutrition. Every nutrition consult contained a detailed examination of food choices, as the patients articulated their likes and dislikes and the nutritionists responded by discouraging some foods and promoting others. In these exchanges there were countless choices to be made: the kind of oil to use, the kind of milk to drink, the kind of fruit to blend into a *licuado*, or the way to prepare vegetables. Even when working within a limited availability of foods (and the common preference to supplement all meals with tortillas), and within economic constraints, each meal presented numerous possibilities of what, and how much, to eat. Yet while *choice* remained a central focus of the discussion, choice was not situated within a framework of personal responsibility but was instead conceived of as shared. “*What we’re going to do here is to try to eat healthy.*” “*We’ll do it bit by bit.*” “*We’re going to have to lose some weight*” “*We’re in for [a challenge].*” Despite the message of individual choice implicit in nutrition protocol, the nutritionists found that an emphasis on personal food choice produced the feeling of anxiety similar to that found in restrictive eating. They viewed eating practices as social, and because of this, as practices that could not be managed by willpower alone. As a result, they treated choice as something that did not (and should not) rest entirely within the decisions of a solitary individual. Instead, the weight of the responsibility implicit in choice, and the subsequent agency produced through the action of choosing, was collectivized.

In my research I saw that patients and nutritionists worked to share the responsibility of changing dietary habits; indeed they envisaged this shared responsibility as the path that would lead to changes in the physical weight—and health—of the body. Mol has described the logic of care as a process without clear boundaries. She writes, “Care is not a (small or large) product

that changes hands, but a matter of various hands working together (over time) towards a result. Care is not a transaction in which something is exchanged (a product against a price); but an interaction in which the action goes back and forth (in an ongoing process)” (2008:18). Rather than require a single actor to make a decision thereby giving rise to a visible form of singular subjectivity, the logic of care operates from a place of shared dependency. It lessens the weight of the self.

There were obvious moments when this shared space broke down, when a fragility in friendship and compassion was exposed, when expressions of inequality and injustice surfaced and medical boundaries materialized, reminding patients and nutritionists of the limitations of intersubjective practices of care. In conversations outside the clinic, nutritionists often reflected on the shortcomings of their services. They were aware they did not accompany patients home for meal preparation or to the market for grocery selection, and they spoke of not experiencing directly in their own bodies the pain the patients described and lived with. The inadequacies of treatment emerged over the course of my time in the hospital, as numerous patients did not see improvements in their blood sugar or cholesterol levels, did not lose weight, did not regain their energy, and continued to live with pain. Under these difficult conditions, as the fault lines of treatment started to emerge, the nutritionists might tell me that they suspected their patients were not following the dietary recommendations. They would underscore the need for patient compliance, and they would shift a formerly shared subjectivity back on the body and behaviors of the patient:

—You must do your part: don’t eat sugar, don’t eat fats. . . .—Because of the illness you have, you must eat well.—A person has to maintain his or her recommended weight. And more than anything, when a person has an illness, then the person must care for his or her constitution. In your case, you must watch your salt consumption. —Here are your recommendations, now you must care for your diet.

Patients, in turn, might begin to hint that they suspected the nutritionists’ advice was not correct. Diet sheets would be taken down from their refrigerators and put into drawers, out of sight. At times patients would simply stop coming to the clinic, as did one woman whose home I visited a few weeks after she missed an appointment. “My situation is hopeless,” she

explained to me. “Nothing I do seems to have any affect on my health, so why spend my time trying to change?” She made reference to being in God’s care now.

The shortcomings of the clinic constitute an important piece of the story I witnessed in the *consulta externa*. But alongside these shortcomings were affective relationships: friendships, networks of support, expressions of compassion and empathy—what I am calling care. I have been showing that these lived expressions of care shape “nutrition-in-action,” wherein the self-body of the patient becomes broadly conceived to include the nutritionist, the family, and the broader community. This must be recognized, or understandings of treatment—including why patients arrive and what the nutritionists and patients achieve in clinical practice— will remain incomplete.

### Discussion and Conclusion: Nutrition-in-Action

I began this article with the suggestion that a framework of power alone can limit understandings of what happens during medical treatment. Whereas in my research I encountered nutritional reports and government weight-loss protocols that mapped neatly on a Foucauldian vision of power, I found that attention to power was insufficient for understanding the intersubjective relationships that formed during clinical practice. Drawing on Mol’s development of “the logic of care,” I analyzed caregiving activities that emerged in the nutrition clinic where I worked, highlighting a shift in responsibility away from the individual and onto a shared self, the focus on communal rather than personal choice, and the emotional bonds that formed between patients and nutritionists. My analysis suggests that even within a Guatemalan public hospital—which might appear to be an ideal site in which to explore the exercise of state authority—relationships that formed between patients and providers could not be reduced to a straightforward exchange of power. Medical power inevitably asserts itself in clinical settings, but my research points to other motivations and desires that also influence treatment as it unfolds in practice.

My examination has clear limitations given that it is built on interactions in a single clinic where the nutritionists were just beginning their careers and optimistic that they could help alleviate patients’ illnesses—illnesses that



numerous anthropologists have suggested have roots in conditions of structural inequalities, rather than in specific dietary decisions, be these decisions individualized or distributed across many (see, esp., Farmer 2003; Rock 2003). Nonetheless, my analysis draws attention to the importance of taking seriously a variety of motivations—currently flattened by a theoretical focus on power—that shapes what happens in clinical settings. When patients around me sought the help of their nutritionists, expressing a desire for more and not fewer nutritional services, this was not because they were being duped by medical power, but because something meaningful happened for them in the clinic. Indeed, it was my own research focus on a single hospital setting that made me unable to dismiss the intimacies, affective ties, and caregiving relationships that did not conform easily to analyses of power. I build on this to suggest that the engaged methods of medical anthropology make the field uniquely positioned to explore the myriad, and sometimes contradictory, influences that underlie the ways in which providers and patients relate to others and themselves. Medical anthropology has contributed important insights into the often-harmful effects of clinical power throughout its history, but it is also well situated to now develop analyses of “good” clinical care, as it is locally enacted.

Returning to a conversation presented above, we can see that a remarkable phenomenological shift happens when Josefina asks Eloida, who is looking at her medical chart, “How am I?” This question transfers Eloida’s well-being from a feeling within her body to an external diagnosis, dependent on a medical record that obscures the history of her illness in laboratory results and faded notes from previous doctors. This is the movement Foucault illuminates when writing: “Gradually, an administrative and political space was articulated upon a therapeutic space; it tended to individualize bodies, diseases, symptoms, lives and deaths; it constituted a real table of juxtaposed and carefully distinct singularities” (1977:144). In this article I have argued that this is not, however, the sum total of treatment. Administrative and political spaces *will* individualize bodies, diseases, symptoms, and deaths. They will undoubtedly encroach on therapeutic spaces. But forms of care continue to exist, working around administrative and political paths. Therapeutic spaces can still be therapeutic.

Decades of anthropological studies have emphasized the inherent interconnectedness between what we sometimes call the “self” and what we

sometimes call “society.” Still, one need only look at dietary protocols and WHO treatment strategies for chronic illness to see that the reification of a solitary self—the self that, alone, must make choices that it will then be held responsible for making—continues. The self imagined in these guidelines aligns conveniently with techniques of neoliberal governance where the rights that one is entitled to through citizenship claims are transferred onto “responsible” and “rational” individuals who must make calculations and choices serving their own self-interest. Marilyn Strathern suggests that the idea that the natural state of a person is as a subject or an object—a self set apart from relations—is a reflection of the “commodity logic” (1988:321) of a Western ontology of personhood that imagines a complexity and diversity in selves and agents, but not in relationships. She describes this as a “root metaphor” of Western culture that leads people to imagine that “things can exist in themselves” (Strathern 1988:135).

I have suggested in this article that the root metaphors of our bureaucratic categories and administrative procedures are not as totalizing as they might appear. If I had limited my research to the realm of public health conferences and publications—official language, and records and papers to be archived—nutrition would present an obvious example of biopower. On the one hand, we have an ethic of personal responsibility encouraging a single-serving portion of a bowl of nutrient-fortified cereal, poured neatly from a box (one cup = 160 calories), instead of an abundant helping of frijoles ladled from a communal pot by someone else so that we don’t control the quantity (we eat what we are given). On the other hand, we have the regulation of human populations with nutritional technologies such as BMI situating individual health within a statistical framework.

Yet care, which is necessarily interpersonal, moves around bureaucratic arenas in which choices about diet, exercise, and health have been individualized and institutionalized. The interactions in the clinic where I worked—the intimacies formed between patients and health care workers, the affections and moments of compassion that will not get stored in archival records—push against grand narratives of subjugation and exploitation. This form of care I have been describing is not a *no* to power’s *yes*; it is not resistance but another way of operating in the world.

The entanglements and shared spheres of desires and dependencies revealed

in my fieldwork suggest that a framework of “power” is often incomplete. Attention to power, even when considered as omnipresent as action, caused me to focus on hierarchies when they were not central to what was happening around me. We experience ourselves through others. We need to care, and to be cared for (see also Borneman 2001). When I started to look at the clinic through a lens of care, instead of through a lens of power, I began to see not hierarchies but affective ties of care and compassion as central to the experiences in nutritional practice. Theories of power might dismiss these experiences as irrational or, to make them rational, they might reinscribe them into a self-based desire. Yet care does not conform to a logic of power that would ask: what is in it for me? People sometimes do, and give, and care, for nothing tangible in return; they bypass a logic of power and enact a logic of care, being at once another and themselves.

## Notes

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1. The use of quotes indicates that I recorded, transcribed, and translated the conversation cited. When I refer to what people say in italics and without using quotes, this indicates

I recorded the conversation in field notes shortly after it took place, but did not preserve it digitally. I have changed all names.

2. I have traveled to Guatemala every summer prior to my fieldwork since 1999, with the exception of 2004.

3. For more on the effort to embrace the “other’s point of view,” regardless of this impossibility, see Ortner 1984:144.

4. Although I cannot fully describe my field site in this article, briefly, it is an atypical Latin American city, comprising two Maya ethnic groups (K’iche’ and Mam) and a nonindigenous population. Reputed to be built in the valley in which Spanish conquistador Pedro de Alvarado killed K’iche’ King Tecún Uma’n in 1524, the city has two names: “Quetzaltenango,” which comes from Nahuatl (brought by the Spanish) and

means “place of the Quetzal,” and “Xela,” from the K’iche’ phrase *Xelaju’*, meaning “beneath the ten spiritual guides,” referring to ten mountains surrounding the city. Today, the busiest outdoor market, where indigenous vendors sell the cheapest fresh fruits and vegetables in the city, is meters from the Pradera Mall, constructed just before the Central American Free Trade Agreement went into effect and designed in “estilo norteamericano” (North American style) with a Wal-Mart, Gap, Adidas store, movie theater, and fast-food court. The city is, in the words of one informant, “a city of contradictions.” In my work, I use the name used by the people with whom I lived to refer to the city—Xela—and not the city’s legal name: Quetzaltenango.

5. The nutritionists, doctors, and patients never referred to race or ethnicity themselves, and I only learned about the students’ backgrounds when I visited their homes or asked them directly about their ethnic–racial origins. When occasional tensions between the students emerged, they framed them to me in economic terms: “She’s not doing her work in the program because she’s working an outside job.” Or “She doesn’t study as hard because she already knows she has a job with her father’s company when she graduates.”

6. The increase in patients was perceptible over the course of my fieldwork, as word of the nutrition services spread between both doctors (many of whom didn’t know about the clinic when I spoke with them) and patients. During my last Thursday in Xela, the newly appointed “Director of Nutrition Outpatient Programs” began her job. The hospital administration, responding to the expanding needs of nutrition services, had allocated funds to hire someone to coordinate and oversee outpatient–nutrition clinical care, which had previously operated under the oversight of students.

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