



Open Library of Humanities



Part of the Ubiquity
Partner Network



Gender in Asia

How to Cite: Runestad, P 2016 The Medical Anthropologist as the Patient: Developing Research Questions on Hospital Food in Japan through Auto-Ethnography. *ASIANetwork Exchange*, 23(1), pp. 66–82, DOI: <http://dx.doi.org/10.16995/ane.161>

Published: 01 March 2016

Peer Review:

This article has been peer reviewed through the double-blind process of *ASIANetwork Exchange*, which is a journal of the *Open Library of Humanities*.

Copyright:

© 2016 The Author(s). This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC-BY 4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. See <http://creativecommons.org/licenses/by/4.0/>.

Open Access:

ASIANetwork Exchange is a peer-reviewed open access journal.

Digital Preservation:

The Open Library of Humanities and all its journals are digitally preserved in the CLOCKSS scholarly archive service.

The Open Library of Humanities is an open access non-profit publisher of scholarly articles and monographs.

GENDER IN ASIA

The Medical Anthropologist as the Patient: Developing Research Questions on Hospital Food in Japan through Auto-Ethnography

Pamela Runestad¹

¹ Creighton University, US
Pamelarunestad@creighton.edu

I was an inpatient at a small maternity clinic in Japan in 2012–13 and found it impossible to separate the way I experienced medical care and my training as a medical anthropologist. As I was encouraged to eat and monitor my weight so that I would “grow” a healthy baby, I recalled how interviewees from my HIV/AIDS project described nourishing their bodies so they could fight disease. Because of my experience in the healthcare system in Japan, I ended up reframing my data to add questions about the role of hospital food in patient care. Meanwhile, I developed the social networks necessary to execute a new project, which I would later undertake. In this essay I argue that medical anthropologists working from a phenomenological perspective may regard their own bodies as assets rather than hindrances in research, and that because bodies are gendered, focusing on this facet of habitus can be particularly informative. I also illustrate how systematic reflection on personal experience in the field (autoethnography) aids in the development of research questions and reframing data. Finally, I discuss how highlighting these steps in research methods courses can demystify the research process for students.

Keywords: Japan; maternal care; HIV/AIDS; methods; autoethnography; medical anthropology

Introduction: The Body and the Research Process

Can we conceptualize bodies as playing a role in the scholarly research process? Among anthropologists, it is becoming more common to consider the body a research asset, a tool through which to understand the embodiment of sociocultural realities (Mascia-Lees 2001). Physician-anthropologist Seth Holmes, for example, describes how he found it necessary to experience the perils of border crossing (hunger, thirst, extreme temperatures, and possible injury from cacti and rattlesnakes), the discomfort of crowded and impoverished living conditions, and the physical stresses caused by bending and crouching to pick berries in order to detail the lives of migrant agricultural workers to the United States (2013). By living like the migrant workers he studied, Holmes sought to embody the structural inequalities inherent in agricultural labor. During the time of his study, his body ached from berry picking, and he lived in a tiny hallway closet-cum-bedroom, sharing an apartment with several other workers. The relatively privileged treatment he experienced as a Caucasian male with a middle-class habitus (he was often mistaken for a “boss” and was even helped by his supervisors in the berry fields) compared to the abuses his Mexican coworkers faced helped Holmes illustrate how race, class, and gender are at the heart of these structural inequalities (*ibid*). Holmes’s description of his experiences, blended with the experiences of his interviewees, is an example of being what Ruth Behar terms “strategically vulnerable” (1996). Holmes is able to encourage readers to understand the pain and suffering of his interviewees by being honest about how he himself suffered (or did not suffer) when he attempted to live as migrant workers do. In this article I argue that this strategic vulnerability, and an awareness of how our personal, embodied situations relate to our anthropological research, has the potential to both enrich and reshape research agendas.

Autoethnography of my own experience living in Japan from 2010–2012, punctuated by a pregnancy and childbirth, reveals how systematic reflection on the habitus and experiences of the researcher can aid in the development of research questions and encourage reframing of existing data.¹ Although as a medical anthropologist, my pri-

¹ I spent several years living in Japan during graduate school, first doing intensive language study and research, then opting to remain in the country while writing my dissertation. This article primarily

mary research dealt with HIV and AIDS and did not focus on maternal health (Runestad 2013), spending time as a patient provided a crucial perspective of how people experience the Japanese health care system. Like Holmes, I found that the combination of strategic vulnerability and embodied experiences enriched my research process.

Other anthropologists have also discussed embodied approaches to their research. Anthropologist, medical practitioner, and clinical psychologist Francine Lorimer describes in her 2010 work how she was able to analyze the setting and patients of a unit in a Dutch mental hospital by examining her emotional reactions to the places and people there. In her words, she used her “emotion as a tool for knowledge in fieldwork” (Lorimer 2010, 123). Lorimer noted her emotional responses, worked through them with therapist-colleagues, and was able to use the resulting data to discern why patients develop successful relationships in the ward but fail to maintain successful relationships outside it, providing a case study that detailed why one patient in particular was rehospitalized on a regular basis. Lorimer’s personal experiences were part of her methodology, and they constitute an innovative way of utilizing the self to collect and analyze data. Like Holmes, Lorimer also makes herself strategically vulnerable to her interviewees and her readers in that she shared personal information with interviewees and what may be considered unorthodox methods with readers. Lorimer’s innovative methods point to the ways in which ethnographers make use of their unique, individualized skills as well as the training they have had in their discipline in order to conduct research.

To give an example closely related to the experiences I will detail below, Tsipy Ivry notes that her status as a pregnant ethnographer in Japan and Israel made it possible for her to conduct research on pregnancy in both locations (2010). As a patient-researcher, she was able to examine the ways in which medical practitioners and laymen from each society relied on biomedicine and biotechnology in culturally patterned ways when interacting not only with pregnant bodies in general, but *her* pregnant body specifically. Through analysis of the use of prenatal diagnostics and maternal weight monitoring, for example, it became clear that the Japanese place

discusses my experience during the dissertation-writing phase.

importance on the mother's body as an "environment" for a developing baby, whereas Israelis place more importance on the genetic makeup of the fetus when striving for fetal health. Like Holmes and Lorimer, Ivry is strategically vulnerable with interviewees and her readers: she shares information about pregnancy with professionals and laypersons in both Israel and Japan, and she notes in her ethnography when these discussions helped further her research. Like Holmes's experience as a doctor-cum-berrypicker, and Lorimer's training as a psychologist, Ivry's pregnancy made it possible for her to use her body, and her embodied experiences, to make sense of a cultural system. Unlike the strategies employed by Holmes and Lorimer, which could theoretically be adopted by researchers of any gender, however, Ivry's female body—her ability to carry a fetus and give birth—is part of her success in conducting this research. From a phenomenological perspective, no biological male could use this strategy.

A key point in these ethnographies is that they enabled their authors to make the necessary social connections to complete the research. Being a doctor (and not just a researcher) made it possible for Holmes to establish relationships with the owners of the Tanaka Farm as well as the local families whose teenagers occasionally worked there over the summer. This, in turn, permitted Holmes the opportunity to understand perspectives of the farm through various ethnic and class lenses. Similarly, Lorimer gained access to the mental facility because of her status as a psychologist-anthropologist, and she utilized her therapist-colleagues to help her process her emotions so that she could analyze the ways in which the relationships she formed with patients were and were not "normal." Finally, as a pregnant patient-anthropologist, Ivry gained access to the medical systems in Israel and Japan, and her practitioners in both places helped her understand her care so that she could analyze the cultural parameters of biomedicine. To put it another way, Holmes, Lorimer, and Ivry used their embodied experiences not only to collect and gain information, but also to gain access to interviewees in the target population. Thus, these anthropologists have systematically used their subjective experiences to push the boundaries of the role of embodied knowledge in ethnography.

As noted above, my own pregnancy, childbirth, and recovery period inadvertently contributed to my analysis of my research. I spent my entire pregnancy in

Japan, and all my pre- and postnatal care was coordinated by a small, 17-bed clinic in Nagano Prefecture. I spent two days there for observation, and eight days there for labor, childbirth, and postnatal care. This is standard practice in Japan, but quite different from the shorter stays common in the United States.

Clinical Experiences in a Japanese Maternity Clinic

In the later stages of my pregnancy, I experienced some pain that concerned my primary doctor, so she admitted me for observation. As I settled into my room at the maternity clinic, a young woman came in and introduced herself as the nutritionist. While in their care, I would get three meals a day and an afternoon snack, all made on-site. Smiling, with pen and paper at the ready, she began questioning me: "Any food allergies?" I shook my head. "Heartburn?" I nodded. "Aversions?" I hesitated, unsure if I should mention things I'm not so fond of eating, or if this was strictly a "that food makes me nauseated or go into anaphylactic shock" question. She seemed to understand the pause, adding, "Things you prefer not to eat?" "Natto² . . ." She smiled knowingly and jotted that down, too. "Japanese food is OK?"

"Yes, I love Japanese food. Especially fish," I replied.

"Got it. Lunch is in about an hour."

The nutritionist returned with a tray and a thermos of tea at noon. I took off all the lids and surveyed the contents of the bowls. Rice, soup, stir-fry, salad, and fruit—a feast. I looked closer at the stir-fry and realized it contained a generous portion of the one other food I do not like and had not thought to mention: liver. Biologically speaking, it makes sense to serve liver to pregnant women—it is high in iron, and pregnant women can be anemic. I took a bite, but found I really couldn't eat any more. I resolved to pick out all the vegetables and eat those instead. But before I got that far, the nutritionist came back to check on me, and right away she said, "Ms. Pamela, can you eat liver? I know many

² *Natto* is a dish of sticky, fermented soybeans with a strong odor. It is usually mixed with soy sauce and mustard, stirred vigorously, and eaten over white rice. It is high in B vitamins.

Americans don't like it." I responded, "Well . . . my mother loves it, but . . ."
Without hesitation, she smiled and said, "It's ok. I'll find something else for you."
Ten minutes later, she brought in a piece of grilled salmon. I marveled at this
attention, which was such a contradiction to the set-menu, "no substitutions"
way of eating in Japanese schools, at large events, and even at restaurants.

(Field notes, Mother's Day 2013)

The nutritionist's questions ranged from what was biologically appropriate to what was culturally appropriate: she queried about food allergies, heartburn (discomfort that would not be captured by the standard biomedical tests conducted in prenatal exams but could be alleviated or exacerbated by certain food choices and is common amongst pregnant women), aversions, and the ability to eat "Japanese" food. Through my charts, she found that I was anemic and would require a concentrated source of iron. The nutritionist considered these factors along with what she had already determined to be a nutritionally balanced, appropriate meal for all the patients at the clinic. When she realized that I had an aversion to one of the foods I was served (liver), she quickly swapped it out with something I had said that I like (fish)—a food that still fit the nutritional guidelines as an appropriate protein. I was also given iron supplements since I had been unable to eat the liver. These negotiations were probably similar to those she had with other (Japanese) patients; however, when faced with a foreign patient, the nutritionist also felt the need to consider that my food consumption might be cultural—hence she attributed my distaste for liver to my being American, and showed visible relief when I told her I like Japanese food. To put it differently, the cultural aspects of determining "nutritionally appropriate food" came to the fore when faced with a foreign patient. Just as Ivry was able to discern how Israelis and Japanese used biomedical technologies differently to encourage fetal development, I was able to see how nutrition is culturally patterned. Moreover, I was able to discern that some Japanese practitioners also see nutrition as both biological and cultural.

Meal Contents and Presentation

Because most women spend about a week in the hospital following giving birth in Japan, they can expect to consume at least 21 meals there. At Maruyama, as is typical of hospitals and clinics across the country, meals and the afternoon snack are prepared for all patients and served at predetermined times. Changes are made based on individual conversations with the nutritionist, as discussed above. Each patient's tray includes a placard that details what she should and should not be served: my own tray, for example, read clearly that I was anemic, that I had requested cold (not hot) tea, and that I was not to be served *natto* or liver (see **Figure 1**).

Meals tend to feature locally grown vegetables, and when bread is served it comes from a local bakery. Each component of a given meal is arranged on separate dishes on a tray and served with a thermos of tea. While some of these meals could be considered "Japanese-style," or *washoku*, because they are comprised of rice, miso

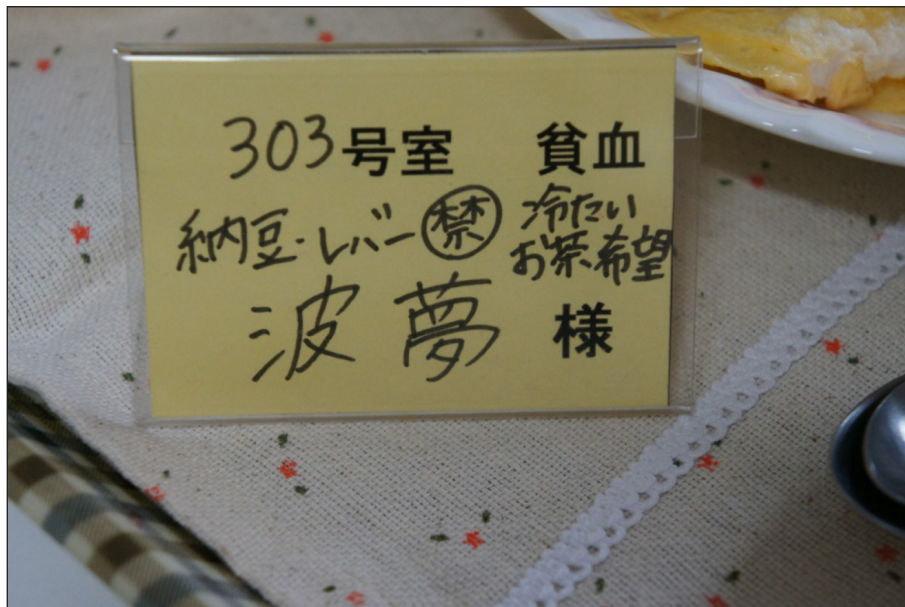


Figure 1: Meal tray placard with patient's name and food proscriptions (*natto*, liver) and prescriptions (anemia supplements, cold tea).³

³ All photographs by the author.



Figure 2: Japanese meal (*washoku*). This meal included rice, vitamin-fortified milk, bean sprout and seaweed salad, potato salad, and tofu scramble.



Figure 3: "Western" breakfast: egg, ham, salad, cheese, banana, and bread.



Figure 4: “Chinese” lunch: lo mein, oranges, egg drop soup, sweet potatoes, and salad.

soup, seaweed salads, and some form of protein, clearly serving a variety of food styles is a priority (see **Figure 2**).

For example, we were served a “Western” breakfast consisting of bread, milk, eggs, salad, banana, and ham one day (**Figure 3**); a “Chinese” lunch of lo mein, oranges, egg drop soup, sweet potatoes, and salad was served another day (**Figure 4**). Dishes that complemented the food style were used.

Special accommodations are also made for laboring women and new mothers. For example, I was admitted to the clinic in the afternoon as a laboring woman. When my dinner was served that night, the midwife carefully rolled the rice from my dinner tray into bite-sized balls (using plastic wrap) and encouraged me to eat as many as I could during early labor so that I would have enough energy for the birth. In the days following the birth, women are offered a “Congratulations Lunch” that acknowledges their hard work during labor and pregnancy and welcomes them to motherhood. My own lunch consisted of an appetizer plate, a petit steak, French



Figure 5: “Congratulations lunch”: appetizer plate, a petit steak, French rolls with butter, a salad, soup, and flan.

rolls with butter, a salad, soup, and flan. It was complemented with a glass of (non-alcoholic) blush wine. Unlike other meals, I was offered a choice between two main courses, the staff served this meal on dinnerware, I was presented with a printed menu, and a table cloth was carefully placed on my table before bringing in the dishes; no tray was used. In other words, the presentation closely resembled being served in an upscale restaurant (**Figure 5**).

Once in a while, meals for all the patients may be prepared with a particular patient in mind. After my baby was born, the nutritionist visited me again and asked what a meal from Alaska (my home state) would look like. I was surprised at this attention, but the nutritionist said it would probably be fun for the patients and for the kitchen staff to try something new. Taking into account what ingredients I thought it would be easy for her to acquire and dishes I thought patients would be likely to tolerate, I described how to prepare mashed potatoes, seared scallops, and seafood chowders. The next day,



Figure 6: “Alaska lunch”: seafood chowder, salad, watermelon, and rice, along with my iron-supplement beverage.

all the inpatients were served an “Alaska Lunch”⁴ that came with a description of the foods that had been prepared—and a description of me (Figure 6).

Making Sense of Maternity Clinic Meals

So what do these observations suggest? First, the food that is served provides a model for what the medical staff view to be a healthy, balanced diet—one that they hope the patients follow after their release from the hospital. In fact, several times during my stay, patients were presented with recipes for the food that was served along with a note saying that they could prepare the same meal for their families. This is reflective, first of all, of the “good wife, wise mother” roles that women continue to be expected to play in Japan, particularly through their provision and preparation of food (Allison 1991). Second, the variety and careful presentation of the recipes reflect the staff’s efforts to stimulate patients’ appetites, which in turn would provide them with the

⁴ Notice that the meal also includes watermelon and a plate of “butter rice”—neither of which are “Alaskan.”

energy to care for themselves and their babies. This demonstrates the biomedical tendency in Japan to focus on creating a healthy environment for the growing fetus (and then newborn) by caring for the mother (Ivry 2010). Third, incorporation of locally grown and produced foods communicates local pride and commitment to fresh foods, a trend many Japanese seem to be following (Rosenberger 2014). Fourth, the attention to individualized care is notable considering that food choices are generally limited in institutional settings. Given the prevalence of set menus and the supposed “group mentality” often found in Japan, this individualization suggests there may be condition-specific and gendered aspects of food prescription in clinics. Are pregnant women perhaps seen as particularly deserving of individualized care due to their importance as carriers of the next generation? Fifth, the offer of food to laboring women marks a cultural difference in terms of biomedical practice: in the United States, for example, women have been told not to eat during labor because of the fear that they may aspirate their food if put under a general anesthetic (although this is changing) (Hubertina et al 2002). This stands in strong contrast to the encouraging words and actions of my midwife, who, rather than restrict my food intake, urged me to eat rice balls she had personally rolled for me. And finally, food can serve as a form of comfort and communication. In the case of the “Alaska” meal, for example, the nutritionist aimed to offer me comfort food, but it also gave her a chance to trade recipes and provided the clinic an indirect method of explaining my presence to the other patients. The patients, in turn, had the opportunity to consume not just exotic foods, but also an exotic location via food consumption, all from the comfort of their beds.

Reframing the Data and Asking New Questions

In the weeks after my child was born, I worked through these ideas in my field notes as I learned how to be a new mother. At a well-baby visit with the assistant director of the clinic (who is also a friend and familiar with my work on HIV/AIDS in Japan), I mentioned how good the food had been when I was an inpatient. She smiled and answered:

Patients need to be able to enjoy their food. It is a simple thing, but it is important. If they cannot enjoy their food, how can they improve their

health? Hospitals now are starting to pay attention to that. Actually, you can compare pregnancy and HIV on this point. The beginning of pregnancy, so many women feel sick. They can't eat, or it makes them sick. When people with HIV start the medications, it often makes them sick. Or foods don't match and they get sick. Pregnant women have some foods they can't eat. So do HIV patients. But in both groups, patients need to eat or the outcome isn't good. So we have to pay attention to individual patients' nutrition, likes/dislikes, and foods they can't eat. (Dr. Watanabe Tomoko, July 2013)

While I had already been comparing notes about how I moved through the medical system as a patient with my interviewees' narratives, Dr. Watanabe's comments helped me reframe what I had learned about HIV/AIDS patients and diet from my interviews in comparison to what I had learned about prenatal care and diet from my own experiences as a patient. In both cases, patients' diets are monitored because a nourished body correlates with better health outcomes—a healthier mother and infant in the case of pregnant women, and a higher rate of tolerance for antiretrovirals (ARVs) in HIV/AIDS patients (who, in Japan, are most likely to be men [UNAIDS 2014]). In addition, pairing ARV dosage with mealtimes improves adherence and tolerance of medication. This is why, as a Japanese pharmacist who specializes in HIV/AIDS care at a large hospital in Osaka stated, "We sit down with patients and talk about their daily routines, what they eat and when, so we can work out what the best treatment regimens for them would be."

In addition to the individualized pharmaceutical regimen prescribed by medical practitioners after HIV/AIDS patient consultations, patients themselves described diets they followed and information about food-drug interactions: "Managing health becomes a strict regimen. You have to keep yourself healthy so you don't get sick. My hospitals don't manage symptoms and side effects, so I do that by making my own food. . . . I can't eat food with lots of garlic with the medications I take. I did that once, and I threw up. . . . If you throw up less than an hour after you take the medications, you have to take them again. . . ." (Mr. E.⁵ August 7, 2011). In addition to linking

⁵ A pseudonym.

health management to diet, Mr. E. also makes it clear that a food item considered healthy (such as garlic) may actually be detrimental to particular patients.

While impoverished HIV/AIDS patients have made it clear that plans to provide ARVs and not food make recovery difficult (Biehl and Eskerod 2007, Kalofonos 2010), and some may find that particular ARVs may make them nauseated, Mr. E. describes how combinations of foods and ARVs can also be a problem. In other words, it is not enough to consider food as nourishment or coordinating pill taking with mealtimes as a way to help patients adhere to their treatment regimens. In the same way that particular foods may cause pregnant women to become nauseated and vomit, specific food-drug combinations can cause people living with HIV/AIDS to vomit. Meals, then, must be patient specific to some degree so that valuable nutrients, and medications, in the case of HIV/AIDS patients, are not lost this way.

These comments about enjoying food, pairing food with medicine to optimize care, and paying attention to food-drug interactions helped me think through the various reasons why patients and practitioners consider diet an important aspect of maintaining health. Comparing what I knew about my own clinic meals to the diets of inpatients and outpatients being treated for HIV/AIDS left me with many questions: How were my dietary prescriptions and proscriptions as an inpatient different from theirs? To what degree were these differences based on gender, age, class, ethnicity, medical condition, rural versus urban area, and size of the medical facility? For example, can nutrition pre- and proscription be explained as support for Japanese mothers because their sexual and reproductive behaviors uphold the status quo? Can nutrition pre- and proscription for Japanese men living with HIV/AIDS be explained as efforts to help them overcome perceptions that their sexual behaviors not only fail to produce children, but also are linked to contracting an incurable, sexually transmitted infection that could put others in danger? Or could it be linked to efforts to help them overcome the misperception that people with HIV are going to die, and thus they cannot work?⁶ What would differences and similarities tell me

⁶ In Japan, the term "person of society" (*shakaijin*) is often used to talk about becoming a "real adult." A *shakaijin* contributes to society by getting an education, starting a career, getting married, and having

about attitudes about nutrition in Japan specifically, and about Japanese biomedical practice in general? If I put together a comparison study in the United States, would I see similar patterns with regard to how patient care depended on the factors I listed above? Suddenly, I found myself with a whole new research project—and the social networks necessary to complete the Japanese part of the project. In fact, when I presented these questions to both the staff at Maruyama and to practitioners in the hospitals I had visited for my HIV/AIDS research, the response was overwhelmingly positive, and I am now in the process of designing this project.

Conclusions

Analyzing the contents and presentation of my clinic-based food experiences (auto-ethnography) inspired several potential lines of inquiry about the role of food in maternity clinics in Japan that may, in turn, provide information about the parameters of food consumption in that country. Making comparisons between my own gendered experiences and food-related comments by my interviewees from a previous project helped me formulate new questions about the intersections of food and the body. Namely, how are production, prescription, consumption, and refusal of hospital food, as well as the way people describe the effects on patient health, functions of local, national, and global health standards and cultural ideals? Turning the anthropological lens on myself while I was a patient helped me identify new research topics and questions, and helped me build the social networks I need to be able to conduct research on these topics. In their recent ethnographies, Holmes, Lorimer, and Ivry describe how they used their bodies to systematically gather and explain data. Likewise, my maternity ward experiences illustrate how reflexivity and auto-ethnography are not just data collection and analysis methods: they can be employed to generate new questions as well. Furthermore, reflexivity and autoethnographic reflection can provide starting points for powerful student research projects. While most anthropologists know the value of their own experience, writing

children. However, I argue elsewhere that being a *shakaijin* is gendered, and the emphasis on these four areas is different for men, who are supposed to be the breadwinners, and women, who are supposed to bear and care for children (Runestad 2013).

about personal situations and discussing them in methods classes helps demystify the research process for students. This may be of particular use when discussing how researchers choose their projects and select strategies for data collection. Thinking through the ways in which analysis can be related to their personal, embodied experiences, whether related to gender or to other identity markers, may help students develop important, interesting questions and approaches.

Competing Interests

The author declares that they have no competing interests.

Author Information

Pamela Runestad is a medical anthropologist and Japanologist with interests in infectious disease (primarily HIV/AIDS), health and nutrition, narrative, and pedagogy. She works in the Department of Cultural and Social Studies at Creighton University, where she teaches undergraduate and graduate courses on anthropological perspectives of healthcare systems and nutrition. Her research was supported by the Osaka City University GCOE and the University of Hawaii, Manoa.

Bibliography

- Allison, A** 1991 Japanese Mothers and Obentōs: The Lunch-box as Ideological State Apparatus. *Japan Anthropological Quarterly*, 64 (4): 195–208. DOI: <http://dx.doi.org/10.2307/3317212>
- Behar, R** 1996 *The Vulnerable Observer: Anthropology That Breaks Your Heart*. Boston: Beacon Press.
- Biehl, J G** and **Eskerod, T** 2007 *Will to Live: AIDS Therapies and the Politics of Survival*. Princeton: Princeton University Press.
- Bourdieu, P** 1990 *The Logic of Practice*. Translated by Richard Nice. Stanford: Stanford University Press.
- Holmes, S** 2013 *Fresh Fruit, Broken Bodies: Migrant Farmworkers in the United States*. Berkeley: University of California Press.
- Ivry, T** 2010 *Embodying Culture: Pregnancy in Japan and Israel*. New Brunswick: Rutgers University Press.

- Kalofonos, I A** 2010 All I eat is ARVs': The Paradox of AIDS Treatment Interventions in Central Mozambique. *Medical Anthropology Quarterly*, 24 (3): 363–380. DOI: <http://dx.doi.org/10.1111/j.1548-1387.2010.01109.x>
- Lorimer, F** 2010 Using Emotion as a Form of Knowledge in Psychiatric Fieldwork Setting. In: Davies, J and Spencer, D (Eds.) *Emotions in the Field: The Psychology and Anthropology of Fieldwork Experience*. Stanford: Stanford University Press, pp. 98–126.
- Mascia-Lees, F E** 2011 *A companion to the anthropology of the body and embodiment*. Chichester, West Sussex, U.K.: Wiley-Blackwell. DOI: <http://dx.doi.org/10.1002/9781444340488>
- Rosenberger, N** 2014 'Making an ant's forehead of a Difference': Organic Agriculture as an Alternative Lifestyle in Japan. In: Kawano, S, Roberts, S and Long, S O (Eds.) *Capturing Contemporary Japan*. Honolulu: University of Hawaii Press, pp. 105–134.
- Runestad, P L** 2013 *Health and Precarity: Living with HIV in Japan*. Doctoral Dissertation. University of Hawai'i at Mānoa.
- Scheepers, H, Thans, M C J, deJong, P A, Essed, G G M, Cessie, S L and Kanhai, H H H** 2002 Eating and Drinking During Labor: The Influence of Caregiver Advice on Women's Behavior. *Birth*, 28(2): 119–123. DOI: <http://dx.doi.org/10.1046/j.1523-536X.2001.00119.x>
- UNAIDS** 2014 Japan Narrative Report. Available at: http://www.unaids.org/sites/default/files/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/JPN_narrative_report_2014.pdf (accessed September 25, 2015).

How to cite this article: Runestad, P 2016 The Medical Anthropologist as the Patient: Developing Research Questions on Hospital Food in Japan through Auto-Ethnography. *ASIANetwork Exchange*, 23(1), pp. 66–82, DOI: <http://dx.doi.org/10.16995/ane.161>

Published: 01 March 2016

Copyright: © 2016 The Author(s). This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC-BY 4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. See <http://creativecommons.org/licenses/by/4.0/>.



ASIANetwork Exchange is a peer-reviewed open access journal published by Open Library of Humanities.

OPEN ACCESS